Community Plan

UnitedHealthcare Community Plan of Iowa – 2016

Physician, Health Care Professional, Facility and Ancillary

Provider Manual

UHCCommunityPlan.com

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Chapter 1: Welcome

This administrative guide is designed as a comprehensive reference for information you and your staff need to conduct your transactions with us in the quickest and most efficient manner possible. Much of this material, as well as operational policies and additional information, are available at UHCCommunityPlan.com.

Our goal is to ensure that our members have convenient access to high-quality care provided according to the most current and efficacious treatment protocols available. We are committed to working with and supporting you and your staff to achieve the best possible health outcomes for our members.

If you have any questions about the information or material in this administrative guide or about any of our policies or procedures, please do not hesitate to contact Provider Services at 888-650-3462. In addition, the UnitedHealthcare Community Plan office is located at:

UnitedHealthcare Community Plan
1089 Jordan Creek Parkway
West Des Moines, IA 50266

We greatly appreciate your participation in our program and the care you provide to our members.

Important Information Regarding the Use of This Guide

In the event of a conflict or inconsistency between your participation agreement and this manual, the provisions of this Manual will control.

We reserve the right to supplement this guide to ensure that its terms and conditions remain in compliance with relevant federal and state statutes and regulations. This guide will be amended as operational policies change.

Communications to Providers

From time to time, there may be important information about policies and protocols that must be communicated to all participating providers. These communications may be done through *Network Bulletins* or through the *Practice Matters* provider newsletter. If the information communicated through these methods is a change to any protocol set forth in this Manual, you will see the updated information in this manual upon the next provider manual revision notification.

Network Bulletin – The Network Bulletin is a monthly publication posted to UnitedHealthcaerOnline.com. This bulletin contains information and updates as well as administrative changes for all providers, not just Medicare, Medicaid, and ***hawk-i***. Articles located in this bulletin that are specific to Iowa Medicaid providers will also be communicated through the provider newsletter called *Practice Matters.*

Practice Matters – *Practice Matters* is the provider newsletter published quarterly specific to Iowa Medicaid products within UnitedHealthcare Community Plan of Iowa. This newsletter includes any policy changes and communicates any clinical topics or reminders. Articles regarding policy or administrative updates will be included in this publication but may also be found in the *Network Bulletin* as specified above. The *Practice Matters* newsletters are posted at UHCCommunityPlan.com For Health Care Professionals > Iowa > Provider Newsletters.

About UnitedHealthcare Community Plan of Iowa

UnitedHealthcare Community Plan of Iowa, a business unit of UnitedHealth Group, seeks to help the people we serve live

healthier lives. We understand that compassion and respect are essential components of a successful health care company. UnitedHealthcare Community Plan employs a diverse workforce, rooted in the communities we serve, with varied backgrounds and extensive practical experience that gives us a better understanding of our members and their needs.

Our Approach to Health Care

Our personalized programs encourage the efficient utilization of quality services. These programs, some of them developed with the aid of researchers and clinicians from academic medical centers, are designed to help members best manage their chronic medical conditions.

Our clinical model helps people live healthier lives through integrated health care and services that support the people we serve, to live a meaningful life in a community of their choice, providing accessible, affordable options focused on improving health literacy, connecting them to a medical/behavioral health home, and maintaining or improving their health, well-being, and highest possible functional status.

Through our Integrated Model, medical, behavioral and long-term care services and supports are fully integrated for all members to ensure seamless care transitions and coordination of health care. Clinical programs - Care Coordination, Utilization Management, Disease Management, and Specialty Programs - are connected through the Interdisciplinary Care Team and a common member record.

Wellness
We recognize the importance of the routine medical exams and screenings for our members. We monitor opportunities to close this gap in care through a universal tracking database which helps us identify members who have not had their HEDIS recommended exam or screenings as indicated. Members who are compliant with recommend exams and screenings are eligible to have their annual insurance premiums waived through the Healthy Behaviors Program. Our Baby Block value added service encourages member compliance for prenatal, postnatal and the First 15 Months of life. Gaps in care reporting is available for your utilization through our online coordination tool, Community Care.

Cultural competency is at the heart of serving our members, their special health needs and their unique circumstances. Cultural sensitivity plays a vital part in realizing our goal of supporting member recovery and resiliency in ways that are meaningful and appropriate for individuals in their communities and relevant to their unique cultural experiences.

Our philosophy for ensuring cultural competency emphasizes a "whole member" approach, taking into account the member's environment, background and culture.

We are also committed to disability competency in which individuals and systems provide services effectively to people with various physical and behavioral disabilities in a manner. This includes modifications of a treatment facility, treatment environment and access. We believe care delivery includes respecting the worth of each individual and preservation his or her personal dignity.

These considerations include:

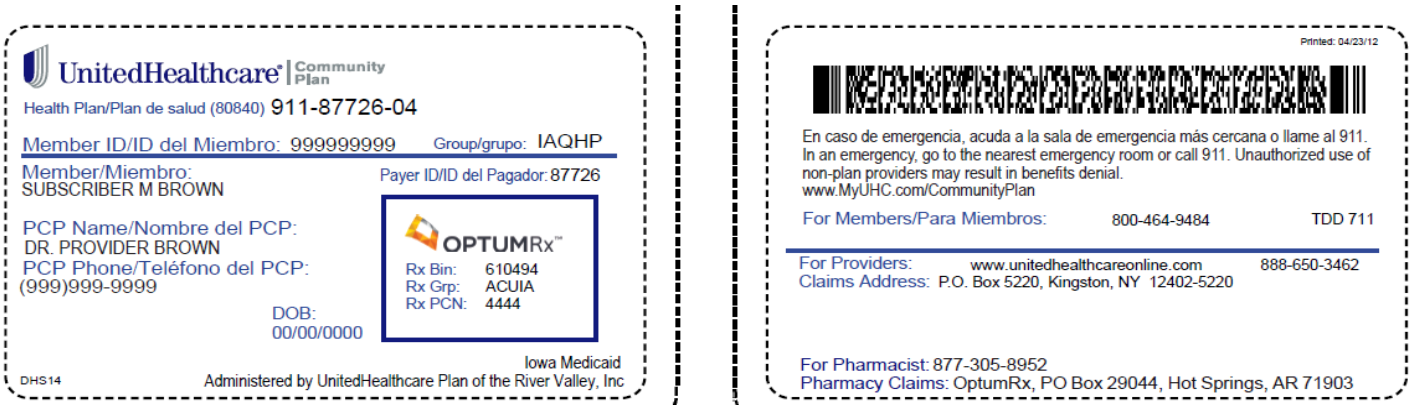
- Compliance with American Disabilities Act (ADA) indicated through policies and procedures
- Mobility and accessibility, including wheelchair ramps and entrance access
- Accessible medical equipment and services adapted to member needs and disability(i.e. adjustable examination table)
- Community resources and assistance, including transportation

In the event that you find that you are unable to assist a member's access needs, including counseling or referral services, you must contact us at 888-650-3462 so that we can refer the member to a network provider who is able to make the necessary accommodations for member care.

Chapter 2: Member ID Cards

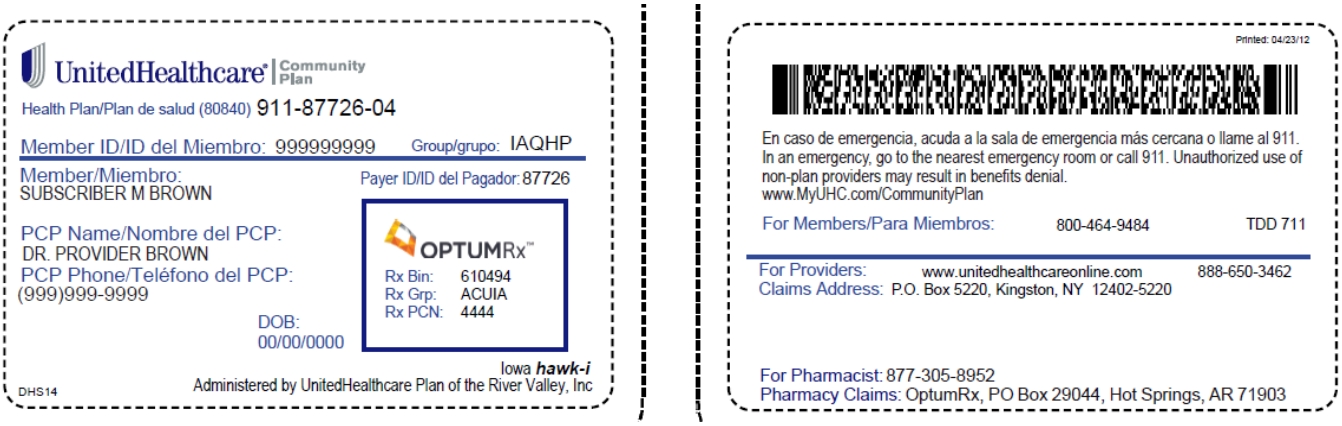
The following represents the member ID cards. Please note that the member's benefit plan is differentiated in the lower, right-hand corner of each ID card:

Medicaid ID Card:

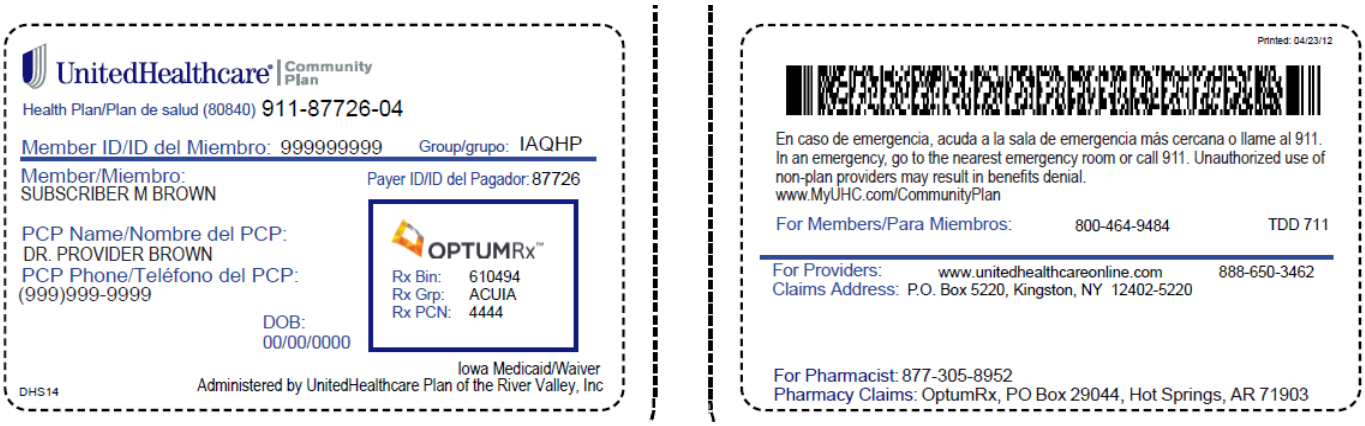


Iowa Wellness ID Card:

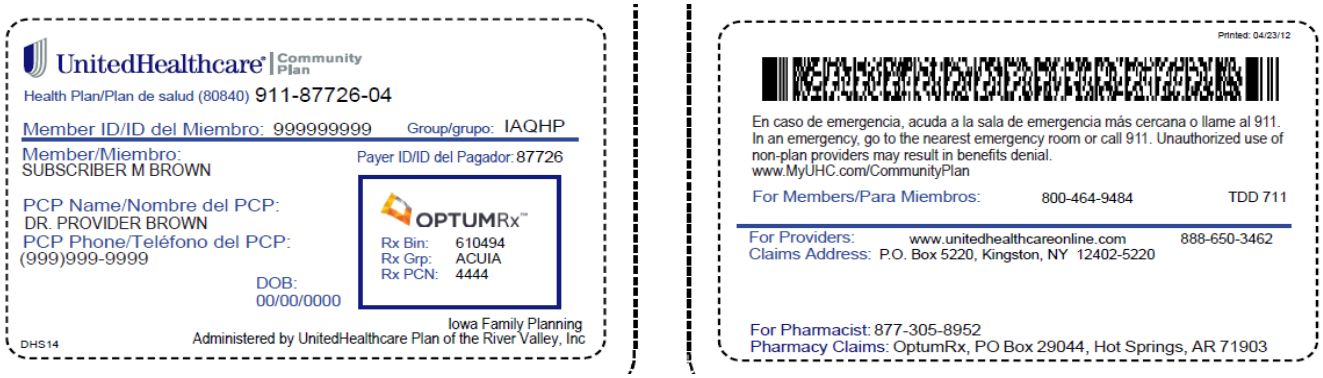
Iowa hawk-I ID Card:



Iowa Medicaid/Waiver ID Card:



Iowa Family Planning ID Card:



Chapter 3: Medical Management:

3.1 Admissions

Prior authorization is not required for emergency services, including transportation. Emergency care should be rendered immediately upon member presentation. Please provide notification to us of an admission by 5 p.m. the following business day through any of the following avenues:

- Visit Cloud.Oputm.com > secure login > Eligibility & Benefits Application.
- Phone: **888-650-3462**
- Fax: **888-899-1680** **(**Fax forms are located at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Forms > Prior Authorization Faxed Request Form.)

- We review emergency admissions within one working day of notification. Please see the Verifying Member Eligibility and Prior Authorization section of this manual for additional information.

Authorization Notification Requirements

UnitedHealthcare Community Plan emergency room admission authorizations/notification must contain the following information:

- Member name and health plan member ID number
- Facility name and Tax Identification Number (TIN) or National Provider Identification (NPI)
- Admitting/attending physician name and TIN/NPI
- Description for admitting diagnosis or ICD-10, or its successor, diagnosis code
- Admission date (Admission to inpatient starts at the time the order is written by a physician that a member's condition has been determined to meet an acute inpatient level of stay.)

UnitedHealthcare Community Plan **prior** authorizations must contain the above criteria with following information:

- Anticipated date(s) of service
- Type of service (primary and secondary) procedure code(s) and volume of service, when applicable
- Service setting
- Facility name and TIN/NPI, when applicable

For Behavioral Health and Substance Use Disorder authorizations, please see the current Network Manual and the Manual Addendum available on providerexpress.com.

Providers who are non-participating with UnitedHealthcare Community Plan of Iowa are required to follow the same guidelines related to prior authorization as participating providers. Prior authorization is not required for all non-participating provider services, however it is required only for those services on the prior authorization list posted to UHCCommunityPlan.com and available in the member record at Cloud.Optum.com We provide

coverage for emergency services without regard to the emergency care provider's contractual relationship with UnitedHealthcare Community Plan of Iowa.

Emergency Defined
An emergency is defined as a medical or behavioral condition, which manifests itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson possessing an average knowledge of medicine and health, could reasonably expect in the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition in serious jeopardy (or, with respect to a pregnant woman, the health of the woman or her unborn child), or in the case of a behavioral condition, perceived as placing the health of the person or others in serious jeopardy
- Serious impairment to such person's bodily functions
- Serious dysfunction of any bodily organ or part of such person
- Serious disfigurement of such person

Urgent Care
Urgent care is the treatment of a health condition, including behavioral, which is not an emergency. However, the condition is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that the person's condition requires medical treatment or evaluation within twenty our (24) hours to prevent serious deterioration.

Please have a plan in place for those members for whom you can reasonably anticipate may require urgent care at some point due to their medical condition; Perhaps a same or next day appointment availability with you or directions for them .

Potentially Preventable Emergency Room Visits
A majority of our members live with chronic and complex medical conditions. We believe that the person-centered care is cornerstone to their medical management. We urge you to practice wellness by closing gaps in care per HEDIS and best practice guidelines.
Please help teach our members to:

- Actively participate in health maintenance activities and care planning
- Recognize worsening symptoms and their triggers
- Have an emergency plan in place and to know when to:
  - Come to your office for a same-or next-day visit with you
  - Visit an urgent care center, or
  - Go to the emergency room

3.2 Delivery Admissions

Prior authorization for delivery is not required as is delivery notification. Please call 888-650-3462 or fax the following information for the newborn to 866-943-6474:

- Date of birth

- Birth weight
- Gender
- Delivery type
- Gestational age

3.3 Newborn Admissions

Prior to or upon a mother's discharge, if the baby stays in the hospital after the mother is discharged. Healthy First Steps will conduct concurrent review of the newborn's extended stay. The hospital should make available the following information:

- Date of birth
- Birth weight
- Gender
- Any congenital defect
- Name of attending neonatologist

3.4 Care Coordination

We screen all our members with an initial health risk screening as they are:

- Newly enrolled to our health plan, within 90 days of enrollment
- Re-enrolling to our health plan who have not been enrolled in the prior 12 months
- Reasonable believed to be pregnant

The initial health risk screening may be conducted in person; by phone; electronically through a secure website or by mail. During the initial health risk screening process, members are offered assistance in arranging an initial visit with their primary care physician (PCP) for a baseline medical assessment and other preventive services.

High-Risk Case Management for Members not in an HCBS Waiver Program

For some members, the results of the initial health risk screening may indicate the potential need for a more in-depth assessment of their needs to best serve them. A care coordinator in our case management program designed for members with high risk conditions will complete a comprehensive assessment by telephone or during a visit to a member's home. The assessment includes: condition of health, history, medications, level of environmental functioning, current provider and service treatment, and member knowledge of their health condition(s) and level of personal health care management. Members who are determined eligible to receive continued services through this program are referred to our care coordination program for enrollment. If they choose to take part of this program, they will then have a person-centered care plan developed with their care team and receive on-going coordination of their care.

Person-Centered Care Model

We use a person-centered care model to manage those members not in an HCBS waiver program. The model includes planning and implementation, which is led by the member where possible. Members are encouraged to choose the participants and those who provider their care. We are dedicated to ensuring our members receive the quality care they need to allow them to live the healthiest possible lifestyle in the community of their choice to the best of their ability. The role of our Complex Community Care Team consisting of the behavioral health advocate, registered nurse, primary care provider, community health worker and member ore representative is to facilitate member care through a team approach based on member need and choice. Through our care coordination we strive to:

- Empower members
- Deliver flexible person-centered care
- Ensure member understanding of their healthcare conditions and prescribed treatment
- Increase member compliance with recommended treatment protocols
- Coordinate care across the healthcare delivery system
- Improve quality outcomes

We utilize CommunityCare, an online planning tool which is accessible by the coordination team, including the member or member representative. Participants are invited to the member record on this platform via email. For more information, visit UnitedHealthcareOnline.com > Tools & Resources > Training and Education > Medicare > Community Care.

Care Plans are updated at least annually or sooner if indicated by a change in member condition or circumstances. A member may request a re-assessment and a re-visit to his or her care plan at any time. Once the plan is in place, our care coordinators continue to monitor service delivery and member treatment participation and circumstances. For more information, please visit UHCCommunitiyPlan.com > For Health Care Professionals > Iowa > Billing and Reference Guides > Our Care Coordination.

If you see a change in member condition or circumstances in your interactions with a member, please report this right away to their care coordinator directly or call Provider Services at 888-650-3462.

3.4 Lock-in Program

The Lock-in Program ensures that members selected for enrollment in the program will use services appropriately and in accordance with department rules and policies. The program limits Lock-In members to one pharmacy, one hospital and one primary care physician for all non-emergent medical care.

A member can be selected for the Lock-in Program review when any one or more of the following occur:

1. A utilization review report indicates the member has not utilized healthcare services appropriately; including, but not limited to: over-utilization, persistent non-compliance, or abusive/threatening conduct;
2. Medical providers, social service agencies, or other concerned parties have provided direct referrals to the State or to UnitedHealthcare Community Plan.
3. Member identified as committing fraud (reported and/or data analytics) or abuse of medical benefits.

When a member is selected for Lock-in Program review, MCO staff (with clinical oversight) reviews their medical and/or billing history to determine if the member has utilized health care services and/or medications at a frequency or amount that is not medically necessary/abusive/excessive.

As a result of the Lock-in Program review, UnitedHealthcare may take any of the following steps:

1. Determine that no action is needed and close the member's file;
2. Send the member and, if applicable, the member's authorized representative, a letter of concern with information on specific findings and notice of potential placement in the Lock-in Program;
3. Refer the member for education on appropriate use of health care services;
4. Refer the member to substance abuse or behavioral health treatment, or to other support services or agencies; or
5. Enroll the member in the Lock-in Program if education and referrals are not successful in changing the member's service utilization.

When a member is initially placed in the Lock-in Program:

1. UnitedHealthcare Community Plan will assist the member in selecting Lock-In providers:
    a. Primary care
    physician
    b. Pharmacy
    c. Hospital
2. The MCO will send the member and, if applicable, the member's authorized representative, a written notice containing at least the following components:
    a. Action MCO intends to take related to

Lock-In.

b. Reason for this action

c. Instructions related to choosing a primary care physician, pharmacy and hospital.

d. Effective date of the lock-in

e. The duration of the enrollment and re-evaluation period

f. Member's right to file an appeal

g. Any other requirements under federal, state laws and regulations

3. The member will remain locked-in to the assigned providers for no less than 24 months unless:

a. The member moves to a residence outside the provider's service area; or

b. The provider moves outside the member's local geographic area and is no longer reasonably accessible to the member.

c. The provider refuses to continue to serve the member.

d. The provider was assigned to the member by the health plan, because the member failed to select a provider. In this case the member may request a change once within 30 calendar days of the initial assignment.

e. The member's current provider no longer participates with the health plan.

A member placed in the Lock-in Program must remain in the Lock-in Program for the initial 24-month period regardless of whether the member changes MCOs or becomes a Fee-for-Service member.

The initial lock-in period is 24 months. Just prior to the end of the 24-month lock-in period, the member will be re-reviewed by UnitedHealthcare Community Plan Lock-In Committee. If the member meets criteria for removal from the Lock-In Program the member will be removed from lock-in and notified in writing. If a member does not meet criteria for lock-in removal, the lock-in will continue and the member will be notified with an explanation regarding on-going lock-in placement.

Provider Participation

Providers participating in UnitedHealthcare Community Plan may opt out of the Lock-In Program by notifying the health plan. When a provider is selected for a Lock-in Program member, the PCP's office is contacted to confirm that the PCP is willing to accept a lock-in patient and that the PCP is accepting new patients. The provider's practice location and appointment availability is also verified.

Providers who participate in the Lock-in Program are expected to meet the following requirements:

1. Providers must be located in the member's local geographic area, and/or be reasonably accessible to the member.
2. The Lock-In PCP supervises and coordinates all Lock-in members' health care services, including continuity of care and referrals to specialists when necessary.

    a. The Lock-In PCP is expected to perform a thorough history and physical examination of the member prior to making referrals to other physicians or providers.

    b. The Lock-In PCP should document the rationale and medical necessity for all referrals in the member's medical record.

    c. A written referral is required for all non-emergent professional provider services and non-emergent outpatient physician services performed at a hospital using the UnitedHealthcare Lock-In Referral Form (see form instructions)

    d. Following inpatient hospitalization, the Lock-In PCP must authorize professional services and a referral is required.

    e. The Lock-In PCP is responsible for identifying the need for a referral and to which provider the member will be referred. Referrals to providers with the same specialty as the Lock-In PCP should be avoided.

    f. The Lock-In PCP should retain prescribing privileges when appropriate, based on the medications prescribed and provider's scope of practice.

    g. After the referral has been made, the Lock-In PCP is expected to provide ongoing management of the member's healthcare.

    h. The referred-to provider must receive the UnitedHealthcare Lock-In Referral Form prior to rendering services and agree to provide only the services requested by the Lock-In PCP. The referred-to provider must submit a copy of the Lock-In Referral Form with their initial claim for payment. Claims will be denied in the absence of a referral, and member will be responsible for payment.

    i. After the requested services are provided by the referred-to provider, a consultation report, including results of any diagnostic test, lab or x-ray, and follow-up or prescribing recommendations should be provided to the Lock-In PCP.

    j. A referral is NOT required for the following services:

        - Non-ambulance medical transportation
        - Home and community based services (HCBS)
        - Community mental health (services only)
        - Durable medical equipment
        - Vision services (Routine eye exams only)
        - Radiology and laboratory services

3. The pharmacy fills all Lock-in members' prescriptions.
4. The hospital provides all Lock-in members non-emergent hospital services.

For suspected Medicaid Fraud or Abuse, contact the Fraud and Abuse Hotline at 866-242-7727

3.5 Family Planning

Family planning services are covered when provided by physicians or practitioners to members who voluntarily choose to delay or prevent pregnancy. Covered services include the provision of accurate information and counseling to allow members to make informed decisions about specific available family planning methods. Members have a choice to receive services from a UnitedHealthcare Community Plan of Iowa provider or go directly to a local health department or family planning clinic. Members do not need a referral for these services. For more information, please see the Iowa Family Planning Manual available at https://dhs.iowa.gov/sites/default/files/FamPlan.pdf.

3.6 Maternity Care

Please notify us promptly of a member's pregnancy status to ensure appropriate follow-up and coordination by our UnitedHealthcare Healthy First Steps team by submitting an American College of Gynecology or other initial prenatal visit form to Healthy First Steps via fax 877-353-6913 or call 888-650-3462.

3.7 Healthy First Steps

Designed to improve birth outcomes and reduce Neonatal Intensive Care Unit (NICU) admissions, the Healthy First Steps program uses early identification to:

- Help overcome common social and psychological barriers to prenatal care
- Increase member understanding of the importance of early prenatal care
- Increase the mother's self-efficacy by identifying and building the mother's support system
- Ensure appropriate postpartum and newborn care
- Develop the physician/member partnership and relationship before and after delivery

Concurrent Review

We do concurrent reviews on hospitalizations for the duration of the stay based on contractual arrangements with the hospital. UnitedHealthcare uses evidence-based, nationally accepted, clinical criteria guidelines for determinations of appropriateness of care.

Discharge Planning and Continuing Care

We are involved in a member's hospital discharge planning. We work with the member, member representatives, physicians, hospital discharge planners, rehabilitation facilities, and home care agencies. We evaluate the appropriate use of benefits, oversee the transition of members between various settings, and refer to community-based services as needed.

Chapter 4: Member Grievances

Members or their authorized representative may file a grievance with us by calling Member Services toll-free at 888-650-3462 or by mailing a written grievance to the address provided below. The timeframe within which a Member must file a grievance is 180 days.

UnitedHealthcare Community Plan of Iowa
Appeals Department
PO Box 31364
Salt Lake City, UT 84131

Members generally receive notification of the grievance resolution within 30 calendar days, but no longer than 60 calendar days from the date of their submission of the grievance.

Member Grievances and Appeals

Our grievance and appeals system is compliant with the Health Insurance Portability and Accountability Act and conforms to applicable federal and state laws, regulations and policies.

Upon enrollment, members receive written information which explains the grievance process. These member materials were developed in accordance with federal regulations and the State of Iowa regarding content, timing and translation of such information. Information is available to you, as the provider, in this provider manual.

Member Appeal Process

When we deny or issue a limited authorization of a service authorization request, or reduces, suspends or terminates a previously authorized service, we mail a Notice of Action to the member. You receive a written notice of the decision. We provide a Notice of Action to the member as expeditiously as his/her health condition requires, but not later than 14 days following the receipt of the authorization request with a possible extension of up to 14 days if the member or provider requests an extension, or if we establish a need for additional information and the delay is in the member's best interest. A member may continue to receive covered services during the appeal process.

Filing a Member Appeal

A representative maybe authorized by a member in writing to act on the member's behalf. The member has 30 plus 3 calendar days if mailed from the date of the Notice of Action to file an appeal. We accept member appeals in writing or verbally. Verbal member appeals must be followed by a written and signed letter which we will mail to the member. The member will need to sign and return the letter to the address listed within 30 days of receipt. Expedited appeal requests are exempt from the written, signed, letter requirement. We make an effort to notify members verbally within one calendar day of the appeal submission for cases accepted as expedited appeals.

Note: Member's cannot ask for an appeal on behalf of the provider.

Timeliness for Resolving a Member Appeal

We resolve standard appeals and appeals for termination, suspension, or reduction of previously authorized services within 30 business days after receipt of the appeal. We will expedite resolution of an appeal if, according to the information provided by the member or as indicated by a provider filing an appeal on the member's behalf, that the standard resolution time frame could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. Under such circumstances, we will resolve the expedited appeal within three business days. If the expedited appeal request is denied, the appeal will be transferred to the standard appeal process. We make every effort to contact the member verbally to notify them of the denial and provide written notice of denial, including the member's right to file a grievance regarding the denial of a request for expedited resolution.

Services while a Member Appeal is being Reviewed

Member benefits continue until a decision is rendered in the following circumstances

- Waiver Services may continue for 90 plus 3 days from the date of the Notice of Action to allow time to file an appeal or request a State Fair Hearing. If a member files an appeal or requests a State Fair Hearing, the current waiver services may continue for the duration of the appeal or the State Fair Hearing.
- Non-waiver Services may continue when the appeal was filed within 10 days of the mailing of the Notice of Action.

No punitive action is taken against a provider who either requests an expedited resolution or supports a member's

appeal.

The Notice of Appeal Resolution contains the date of resolution, reasons for the determination in easily understood language, and a written statement of the clinical rationale for the decision, including how the requesting provider or enrollee may obtain the decision making criteria. For appeals not resolved wholly in favor of the member the Notice of Appeal Resolution will include:

- The member's right to request a fair hearing at any step in the appeals process (including the requirement that the member must file the request for a hearing no later than 30 plus 3 calendar days if mailed from the date of the Notice of Appeal Resolution) and how to make the request
    - Include information on the member's right to receive services while the hearing is pending and how to make the request.

Member Requests for State Fair Hearing

A State Fair Hearing shall mean an Appeal as defined in Exhibit A. The member shall be required to exhaust their Appeal with UnitedHealthcare prior to pursuing a State Fair Hearing.

State Fair Hearing: Member's or their authorized representatives can ask the DHS Appeals Section to review the outcome of an appeal decision made by us if there is a disagreement with the appeal outcome. State Fair Hearing requests must be submitted to DHS no later than 90 calendar days
from the date of the Notice of Appeal Resolution.

- Members can ask for a State Fair Hearing ***instead of*** a UnitedHealthcare Community Plan of Iowa appeal ***or at the same time*** as the UnitedHealthcare Community Plan of Iowa appeal, DHS Appeals Section must receive the State Fair Hearing request within 90 days of the mailing date of the Notice of Action.
- Members can ask for a State Fair Hearing ***after*** UnitedHealthcare Community Plan of Iowa has decided the UnitedHealthcare Community Plan of Iowa appeal. The DHS Appeals Section must receive the request for a State Fair Hearing within 90 days after the mailing date of the UnitedHealthcare Community Plan of Iowa's response letter advising of the outcome of our appeal review.
- There are two ways for members to ask for a State Fair Hearing:

    1. Call our Member Services at 888-650-3462
    2. Send a letter to:
       Department of Human Services
       Appeals Section
       1305 E. Walnut St, 5th Floor
       Des Moines, IA 50319
       Phone: 515-281-3094
       FAX: 515-564-4044
       Email: appeals@dhs.state.ia.us

Reversal of Initial Decision

If UnitedHealthcare of Iowa or the DHS Appeals Sections reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, we will promptly authorize delivery of the disputed service. If the decision reverses a decision to deny authorization of services and the disputed services were received pending appeal, we will pay for those services as specified in policy and/or regulation.

Chapter 5: Quality Management

Clinical Practice Guidelines

We review and update the appropriateness of our adopted clinical practice guidelines in consideration of the needs of our members. We select the guidelines that most align with our expectations of care for our members. We focused on conditions predominately experienced by our members such as:

- Asthma
- Cardiovascular disease
- Chronic Obstructive Pulmonary disease
- Diabetes
- Major Depression
- Prenatal Care
- Post-Partum care

These guidelines are intended to assist you in clinical decision making by describing a range of generally acceptable approaches to the diagnosis, management, and prevention of specific diseases or conditions. The guidelines attempt to define practices that meet the needs of most patients in most circumstances. The ultimate judgment about care of a particular member rests with you as the healthcare provider in light of all the circumstances presented by a particular member. A full listing of the guidelines is located at UHCCommunityPlan.com > For Healthcare Providers > Iowa> Clinical Practice Guidelines.

Health Effectiveness Data and Information Set (HEDIS®)

HEDIS is a uniform tool designed to provide purchasers and consumers with the information they need to reliably compare the performance of health care plans. It measures performance on important dimensions of care and service. In our accountability to these standards we look to you as the healthcare provider.Gaps in care are opportunities to satisfy wellness criteria. For example, a member gap in care could be a postpartum visit that has not yet occurred. Data is collected through claims and pharmacy utilization. Please note that these measures may change from year to year. For more information visit The National Committee for Quality Assurance (NCQA) which publishes HEDIS at NCQA.org > HEDIS Quality Measurement.

HEDIS Measures (not all inclusive)

- Adolescent Well-Care Visits
- Adults' Access to Preventive/ Ambulatory Health Services
- Antidepressant Medication Management
- Appropriate Treatment for Children With Upper Respiratory Infection

- Asthma Medication Ratio
- Childhood Immunizations (we commit to the Combo 4 series)
- Children's and Adolescents' Access to Primary Care Practitioners
- Comprehensive Diabetes Care
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder
- Who Are Using Antipsychotic Medications
- Follow-Up After Hospitalization for Mental Illness
- Follow-Up Care for Children Prescribed ADHD Medication
- Frequency of Ongoing Prenatal Care
- Medication Management for People With Asthma
- Prenatal and Postpartum Care
- Use of Appropriate Medications for People With Asthma
- Well-Child Visits in the First 15 Months of Life
- Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Maintaining Medical Record Documentation Standards

High volume providers are selected for record review no more frequently than every three years. Three charts per provider will be reviewed to determine compliance with medical record documentation standards. In the event that you receive a score below 85% on your chart audit, an additional 5 charts will be reviewed to ensure that a representative sample of charts was examined. If after further review results in a score below 85 percent, then you will be re-audited in six months. In the event that the re-audit does not receive a passing score, actions may include education and counseling, further audits, and recommendation for termination of contract for non-compliance with Medical Record Documentation Standards.

Clinical data needs to be provided to UnitedHealthcare Community Plan consistent with state and federal law including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the American Recovery and Reinvestment Act of 2009 (ARRA) and the Clinical Laboratory Improvement Act (CLIA). Evidence of data provenance will be provided upon request by us to satisfy National Committee for Quality Assurance (NCQA) audits or other compliance requirements. You need to ensure that the data submitted is accurate and complete, meaning all clinical data will represent the information received from the ordering physician and all results from the rendering provider.

We verify that security measures, protocols, and practices are compliant with HIPAA regulation and our e data usage, governance, and security policies, and will be used for the lawful receipt of clinical data from care providers. Any clinical data received will be used only as allowed under applicable state and federal law. We use this data to perform treatment, payment or health care operations – as defined in HIPAA – for its members. Our operations may include the following:

- Compliance with state and federal data collection and reporting requirements, including, but not limited to, Healthcare Effectiveness Data and Information Set (HEDIS), NCQA accreditation, Centers for Medicare & Medicaid Services' (CMS) Star Ratings, and CMS Hierarchical Condition Category Risk Adjustment System
- Care coordination and other care management and quality improvement programs including physician performance, pharmaceutical safety, customer health risks using predictive modeling and the subsequent development of disease management programs used by UnitedHealthcare and other member and care provider health awareness programs
- Quality assessment and benchmarking data sets

- Any other lawful health care operations

HIPAA minimum necessary data requirements are defined in specific documents related to the method of clinical data acquisition, including HL7 companion guide(s) and process documentation related to proprietary file exchange, fax submissions, paper data submission and/or manual data collection by UnitedHealthcare authorized personnel. The companion guides are available at uhc.com/hipaa-and-edi/companion-docs, numbers 11 and 12.

Protect Confidentiality of Member Data

Medical records reflect all aspects of patient care, including ancillary services. Members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates that need that information to fulfill contractual service obligations and to facilitate improvements to member health care.

We require our associates and business associates to protect privacy and abide by privacy laws. If a member requests specific medical record information, we refer the member to you as the primary holder of the medical records. Applicable regulatory requirements need to be observed, including but not limited to those related to confidentiality of Medical information. Our care providers agree to comply in all relevant respects with the applicable requirements of the Health Insurance Portability Accountability Act of 1996 (HIPAA) and associated regulations, including applicable state laws and regulations.

5.2 Credentialing and Recredentialing Process

UnitedHealthcare's credentialing and recredentialing process is to determine the provider's competence and suitability for initial and continued inclusion in UnitedHealthcare's provider network. All individual contracted providers are subject to the credentialing and recredentialing process before they can evaluate and treat UnitedHealthcare members.

5.3 Resolving Provider Disputes

If you have a concern or complaint about your agreement with us, complete the Provider Dispute form found on at UHCCommunityPlan.com/health-professionals/ia/provider-forms.html:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

A representative will look into your complaint and try to resolve it through informal discussions. If you disagree with the outcome of this discussion, please follow the dispute resolution provisions of your applicable Provider Agreement.

If your concern or complaint relates to a matter which is generally administered by certain UnitedHealthcare procedures, such as the credentialing or Care Coordination process, we will follow the procedures set forth in those plans to resolve the concern or complaint.

In the event a member has authorized you to appeal a clinical or coverage determination on their behalf, that appeal will follow the process governing member appeals outlined in the Member Handbook.

5.4 HIPAA Compliance – Provider Responsibilities

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 is aimed at improving the efficiency and effectiveness of the health care system in the United States. While the portability and continuity of insurance coverage for workers and greater ability to fight health care fraud and abuse were the core goals of the Act, the Administrative Simplification provisions of HIPAA have had the greatest impact on the operations of the health care industry. UnitedHealthcare is a "covered entity" under the regulations as are all health care providers who conduct business electronically.

1. Transactions and Code sets

These provisions were originally added because of the need for national standardization of formats and codes for electronic health care claims to facilitate electronic data interchange (EDI). From the many hundreds of formats in use prior to the regulation, nine standard formats were adopted in the final Transactions and Code sets Rule. All providers who conduct business electronically are required to do so utilizing the standard formats adopted under HIPAA or to utilize a clearinghouse to translate proprietary formats into the standard formats for submission to UnitedHealthcare.

2. Unique Identifiers

HIPAA also requires the development of unique identifiers for employers, health care providers, Health Plans and individuals for use in standard transactions. Please see the National Provider Identifier section of this chapter.)

3. Privacy of Individually Identifiable Health Information

The privacy regulations ensure a national floor of privacy protections for patients by limiting the ways that Health Plans, pharmacies, hospitals and other covered entities can use patients' personal medical information. The regulations protect medical records and other individually identifiable health information, whether it is electronic, paper or oral.

The major purposes of the regulation are to protect and enhance the rights of consumers by providing them access to their health information and controlling the inappropriate use of that information; also, to improve the efficiency and effectiveness of health care delivery by creating a national framework for health privacy protection that builds on efforts by states, health systems, and individual organizations and individuals.

4. Security

The Security Regulations require covered entities to meet basic security objectives.

1. Ensure the confidentiality, integrity and availability of all electronic protected health information (PHI) the covered entity creates, receives, maintains and transmits;
2. Protect against any reasonably anticipated threats or hazards to the security or integrity of such information;
3. Protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the Privacy regulations;
4. Ensures compliance with the Security Regulations by the covered entity's workforce.

UnitedHealthcare expects all participating providers to be in compliance with the HIPAA regulations that apply to their practice or facility within the established deadlines. Additional information on HIPAA regulations can be obtained at cms.hhs.gov.

5.5 Member Rights and Responsibilities

Privacy Regulations

HIPAA Privacy Regulations provide comprehensive federal protection for the privacy of health care information. These regulations control the internal uses and the external disclosures of health information. The Privacy Regulations also create certain individual patient rights.

Access to Protected Health Information

- UnitedHealthcare members have the right to access health information maintained in a designated record set held at the provider's office or at the Health Plan. Members may make a request to see and obtain a copy of certain health information UnitedHealthcare maintains electronically, such as medical records and billing records. They may also make a request of the provider of service to obtain copies of their health information maintained electronically. If members' health information is maintained electronically, members can request the Health Plan or provider send a copy of their electronic health information in an electronic format. They can also request that a copy of their health

information be provided to a third party they identify.

Amendment of PHI

• UnitedHealthcare members have the right to request information held by the provider or Health Plan be amended if they believe the information to be inaccurate or incomplete. Any request for amendment of PHI must be in writing and provide reasons for the requested amendment. The request must be acted on within 60 days. This limit may be extended for a period of 30 days with written notice to the member. If the request is denied, members may have a statement of disagreement added to t he member's health information.

Accounting of Disclosures

• UnitedHealthcare members have the right to request an Accounting of certain Disclosures of his or her PHI made by the provider or the Health Plan during six years prior to the request. This accounting must include disclosures by business associates. The accounting will not include disclosures of information made: (i) for treatment, payment and health care operations purposes; (ii) to members or pursuant to members authorization; and (iii) to correctional institutions or law enforcement officials; and (iv) other disclosures for which federal law does not require UnitedHeathcare to provide an accounting.

Right to Request Restrictions

• Members have the right to request restrictions to the provider or Health Plan's uses and disclosures of the individual's PHI for treatment payment and healthcare operations. Such a request may be denied, but if it is granted, the covered entity is bound by any restriction to which is agreed and these restrictions must be documented. Provider and Health Plan must agree to individual's request to restrict disclosure. Members have the right to request restriction on uses or disclosures of their information for treatment, payment, or health care operations. In addition, members may request to restrict disclosures to family members or to others who are involved in their healthcare or payment for their healthcare.

Right to Request Confidential Communications

• Members have the right to request that communications from the provider or the Health Plan be received at an alternative location or by alternative means. A provider will accommodate reasonable requests and may not require an explanation from the member as to the basis for the request, but may require the request be in writing. A Health Plan must accommodate reasonable requests if the member clearly states the disclosure of all or part of that information could endanger the member.

We tell our members they have certain rights and responsibilities, all of which are intended to help uphold the quality of care and services they receive from you. The three primary member responsibilities as required by the NCQA are:

1) A responsibility to supply information (to the extent possible) that the organization and its providers need in order to provide care

2) A responsibility to follow plans and instructions for care that they have agreed to with their providers

3) A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible

Member rights can be found at UHCCommunityPlan.com, and are listed below for your reference.

Member Rights

UnitedHealthcare will follow any federal and state laws regarding member rights. We will make sure that we and our providers respect those rights. UnitedHealthcare members have a right to:

- Be cared for with respect and dignity, no matter what their health status, sex, race, color, religion, national origin, age, marital status or sexual orientation.
- Be told where, when and how to get the services they need from UnitedHealthcare.
- Be told by their primary care provider what is wrong, what can be done for them, and what is likely to happen, in a language they understand.
- Learn about all treatment choices, in a way appropriate to their condition and ability to understand.
- Get a second opinion about their care by a provider in or out of the UnitedHealthcare network, at no cost.
- Give their OK to any treatment or plan for your care after that plan has been fully explained to them.
- Refuse care and be told what they may risk if they do.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Choose a primary care provider from the UnitedHealthcare network, including the right to refuse care from specific providers
- Get a copy of their medical record, and talk about it with their primary care provider.
- Ask, if needed, that their medical record be corrected.
- Be sure their medical record is private and that it will not be shared with anyone except as required by law, contract, or with their approval.
- Use the UnitedHealthcare grievance system to settle any grievances. Or, submit any grievances to the state of Iowa if they feel they were not fairly treated.
- Exercise their rights, as long as it does not cause a problem with the way UnitedHealthcare and its providers or the state agency treats them.
- Use the Administrative Hearing System.
- Allow someone (relative, friend, lawyer, etc.) to speak for them if they are unable to speak for themselves about their care and treatment.
- Receive kind and respectful care in a clean and safe place free of unnecessary restraints.
- Ask for and get information about physician incentives.
- Ask for and get information about UnitedHealthcare, its services, the providers providing care, and members' rights and responsibilities.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To write advance directives.
- Have services provided in a culturally competent manner, with consideration for limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, or visual or auditory limitations. Options include access to a language interpreter, a person proficient in sign language for the hearing impaired, and written materials available in

Braille for the blind or in different formats, as appropriate.

- Have the right to see an out-of-network provider, if no participating network provider is available, at no additional cost beyond what they would pay if services were furnished within the network.

5.6 National Provider Identifier

NPI is the standard unique identifier (a 10 character number with no imbedded intelligence) for health care providers under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which covered entities must accept and use in standard transactions.

The NPI number is issued by the National Plan and Provider Enumeration System (NPPES) and should be shared by the provider with all impacted trading partners such as providers to whom you refer patients, billing companies, and Health Plans.

The NPPES assists providers with their application, processes the application and returns the NPI to the provider.

There are two entity types for the purposes of enumeration. A Type 1 entity is an individual health care provider and a Type 2 entity is an organizational provider, such as a hospital system, clinic, or DME providers with multiple locations. Type 2 providers may enumerate based on location, taxonomy or department.

Only providers who are direct providers of health care services are eligible to apply for an NPI. This creates a subset of providers who provide non-medical services who will not have an NPI.

How to get an NPI

Health care providers can apply for NPIs in one of three ways:

- For the most efficient application processing and the fastest receipt of NPIs, use the web-based application process. Simply log onto the National Plan & Provider Enumeration System - Home Page and apply online at https://nppes.cms.hhs.gov/NPPES.
- Health care providers can agree to have an Electronic File Interchange (EFI) organization (EFIO) submit application data on their behalf (i.e., through a bulk enumeration process) if an EFIO requests their permission to do so.
- Health care providers may wish to obtain a copy of the paper NPI Application/Update Form (CMS-10114) and mail the completed, signed application to the NPI Enumerator located in Fargo, ND, whereby staff at the NPI Enumerator will enter the application data into NPPES. The form will be available only upon request through the NPI Enumerator. Health care providers who wish to obtain a copy of this form must contact the NPI Enumerator in any of these ways:
  - Phone: 800-465-3203
    or
    TTY: 800-692-2326
  - Mail: NPI Enumerator
    P.O. Box 6059
    Fargo, ND 58108-6059

– Email: customerservice@npienumerator.com

5.7 Fraud and Abuse

Fraud and abuse by providers, members, Health Plans, employees, etc. hurts everyone. Your assistance in notifying us about any potential fraud and abuse that comes to your attention and cooperating with any review of such a situation is vital and appreciated. We consider this an integral part of our mutual ongoing efforts to provide the most effective health outcomes possible for all our members.

Definitions of Fraud and Abuse

Fraud: An intentional deception or misrepresentation made by a person with the knowledge the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Abuse: Provider practices that are inconsistent with sound fiscal, business or medical practices and result in an unnecessary cost to the program or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Program.

Examples of fraud and abuse include:

- Misrepresenting Services provided, such as billing for services or supplies not rendered or misrepresentation of services/supplies.
- Falsifying Claims/Encounters, such as
- Incorrect coding, double billing or false data submitted in a claim.

Reporting Fraud and Abuse

You do not have to prove, but if you suspect Medicaid or welfare fraud, waste or abuse, you have a responsibility and a right to report it. Reports of suspected fraud or abuse can be made by calling:

- Call us at 888-650-3462 or
- Contacting the State of Iowa for Medicaid and Welfare Fraud and Abuse at 800-831-1394.

Chapter 6: Hospital Services

This is the provider specific section of the manual. This section was designed to provide information and instructions specific to hospital providers. It is divided into three subsections: Billing Instructions, Benefits and Limitations, and Appendices.

The billing instructions subsection provides directions on how to complete and submit the billing forms applicable to hospital services.

The Benefits and Limitations sub-section defines specific aspects of the scope of hospital services.

HIPAA Compliance

Providers are required to comply with compliance reviews and complaint investigations conducted by the Secretary of the Department of Health and Human Services as part of the Health Insurance Portability and Accountability Act (HIPAA) in accordance with section 45 of the code of regulations parts 160 and 164. Providers are required to furnish the Department of Health and Human Services all information required by the department during its review and investigation. The provider is required to provide the same forms of access to records to the Medicaid Fraud and Abuse Division of the Iowa Attorney General's Office upon request from such office as required by K.S.A. 21-3853 and amendments thereto.

A provider who receives such a request for access to or inspection of documents and records must promptly and reasonably comply with access to the records and facility at reasonable times and places. A provider must not obstruct any audit, review or investigation, including the relevant questioning of employees of the provider. The provider shall not charge a fee for retrieving and copying documents and records related to compliance reviews and complaint investigations.

6.1 Hospital Billing Instructions

Introduction to the UB-04 Claim Form

Hospital providers must use the UB-04 red claim form when requesting payment for medical services and supplies provided under. Any UB-04 claim not submitted on the red claim from will be returned to the provider. An example of the UB-04 claim form is on both the public and secure websites.

Instructions for completing this claim form are included in the following pages. UnitedHealthcare will be using electronic imaging and optical character recognition (OCR) equipment. Therefore, information will not be recognized if not submitted in the correct fields as instructed.

The following numbered form locators (FL) are to be completed when required or if applicable.

Completing the UB-04 claim form: xx refer to CMS for most current
To submit claims electronically: have your office software vendor make connection to our clearinghouse OptumInsight, www.OptumInsight.com. Be sure to use our electronic payer (ID 87726) to submit claims to us. For more information, contact your vendor or our Electronic Data Interchange (EDI) unit at 800-210-8315. You may also submit claims online at www.UHCCommunityPlan.com.

If you do not have access to Internet services, you can mail the completed claim to:
UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

6.2 MS-2126 Form

Notification of Nursing Facility Admission/Discharge MS-2126

The completion of the MS-2126 (Notification of Nursing Facility Admission/Discharge) must be completed by the provider and a copy sent to the local SRS office of Economic & Employment Specialist (EES). Submission of the MS-2126 is not required as a prerequisite for a hospital "reserve day." However, the MS-2126 must be retained in the beneficiary's file for documentation. Completion of the MS-2126 is not required for payment of a therapeutic reserve day.

Facilities must also submit the Case Activity Report (CAR) to DHS.

Chapter 7: Durable Medical Equipment

Durable Medical Equipment (DME) is defined as equipment which is all of the following:

1. Able to withstand repeated use
2. Primarily and customarily used to serve a medical purpose
3. Appropriate for use in the beneficiary's home
4. Generally not useful to a person in the absence of illness or injury

DME may be provided to beneficiaries who:

- Require DME for life support
- Would require higher cost care without DME
- Require DME for employment purposes

A medical supply may be provided when all of the following apply:

1. It is necessary and reasonable for the treatment of the patient's illness/injury.
2. It will be used in the beneficiary's home.
3. It is prescribed appropriately.
4. It is indicated as a covered item.

Definition of "Necessary and Reasonable"

Although an item is classified as DME or medical supply, it may not be covered in every instance. Coverage is based on the fact that the item is necessary and reasonable for treatment of an illness/injury or to improve the functioning of a malformed body part.

It is your responsibility prior to service delivery to verify member eligibility and to secure any necessary prior authorizations for services. For more information, please see the Verify Eligibility and Prior Authorization section of this manual.

Definition of "Beneficiary's Home"

- His or her own dwelling
- An apartment
- A relative/caretaker's home

Dispensing/Prescribing Requirements

The date of receipt of the prescription (ordering date) will be considered the date of service and the provider may bill UnitedHealthcare Community Plan before the actual dispensing of the item(s), since the intent to render service has been confirmed by the acceptance of the prescription.

DME supplies provided on an ongoing routine basis that have limitations may be billed using the dates the services will be used. This allows providers delivery or mailing time. Providers are expected to follow all limitations for the individual supply. Providers cannot bill future dates. For providers to receive payment when billing a date range, the claim will have to be filed on or after the last date on the claim.

UnitedHealthcare Community Plan will only accept prescriptions for DME/Medical Supply items from:

1. Doctors of Medicine (M.D.)
2. Doctors of Osteopathy (D.O.)
3. Doctors of Podiatric Medicine (D.P.M.)
4. Doctors of Chiropractic (D.C.) – may prescribe cervical collars and "soft type" spinal supports only
5. Advanced Registered Nurse Practitioners (ARNP) only if:
   - They are treating the beneficiary for the condition for which the item is needed.
   - They currently are assigned their own individual provider number.
   - They are permitted to do all of the above in the state in which the services are rendered.
6. Physician assistants (PAs) may prescribe only if:
   - They are permitted to perform services in accordance with state law.

- They are treating the beneficiary for the condition for which the item is needed.
- They are practicing under the supervision of a M.D. or D.O.
- They currently are assigned their own individual provider number.

UnitedHealthcare Community Plan of Iowa will reimburse the following providers for the dispensing of Durable Medical Equipment (DME) items:

1. DME/medical supply dealers
2. Pharmacies
3. Home Health Agencies
4. Rural Health Clinics (medical supplies only)

To verify services provided in the course of a post payment review, providers shall retain in their files the prescription signed by the physician

Many low cost items may only be purchased; rental is non-covered.

All DME services are covered for in-home use only. DME services (purchase or rental) are non-covered in nursing facilities, swing bed facilities, state institutions, intermediate care facilities/mental retardation (ICF/MR), psychiatric residential treatment facilities (PRTF), head injury facilities (HI), rehabilitation facilities, and hospitals.

Note: If the facility receives a per diem rate for a beneficiary, the DME services are considered included in the per diem and are the responsibility of the facility.

Delivery, Repair, Maintenance and Installation

The **delivery** of a DME item is covered only when the equipment is initially purchased or rented and the supplier customarily makes a separate charge for delivery.

Proof of Delivery is required in order to verify that the beneficiary received the DME supplies or prosthesis. DME and Prosthetic and Orthotic suppliers are required to maintain proof of delivery in their files. Proof of delivery documentation must be made available to upon request.

We will recoup payment for services in a post-pay review if you do not have adequate proof of delivery in your records. If a pattern appears of not providing documentation to support claimed services, we may refer the situation for investigation by the Fraud Unit which may ultimately lead to a termination of yor the provider agreement with our network.

Direct Delivery

If you and your employees, or anyone else having a financial interest in the delivery of the item are prohibited from signing and accepting an item on behalf of a member. The relationship of the person receiving the delivery for the member must be noted on the delivery slip obtained by the person delivering the item. The signature of the recipient must be legible. If the signature of the designee is not legible, the person making the delivery must note the name of the person receiving the delivery on the delivery slip.

An example of proof of delivery is having for your records a signed delivery slip that includes all of the following:

1. Member name
2. Delivery address
3. Quantity delivered
4. Detailed description of the item being delivered
5. Brand name
6. Serial number, if applicable
7. Signature of the member or or other person receiving the delivery
8. Relationship of the person receiving the delivery to the member
9. Date of signature on the delivery slip (Must be the date that the item was received by the member or someone else on their behalf.)

Delivery by Shipping Service (such as UPS, Federal Express)

The same procedure as outlined above for a direct delivery to a member by your company, also applies to delivery by a third party such as the United Parcel Service or Federal Express. The relationship of the person receiving the deliver to the member should be noted on the delivery slip, if possible, but is not required for this type of shipping. When using this type of delivery service, proof of delivery would include the service's tracking slip and your own shipping invoice. If possible, your records should also include the delivery service's package ID number for that package sent to the beneficiary. The shipping service's tracking slip should reference each individual package, the delivery address, the corresponding package ID number given by the shipping service, and the date delivered, if possible.

You may also use a return postage-paid delivery invoice from the member or another person receiving the delivery as a form of proof of delivery. The descriptive information concerning the item (beneficiary's name, quantity, detailed description, brand name, and serial number) as well as the required signatures from either the beneficiary or the beneficiary's designee should be included on this invoice as well.

Repairs of DME equipment require PA. Providers may bill for the labor component under or plus the appropriate part code.

Maintenance of rental equipment (testing, cleaning, regulating and checking equipment) is considered the responsibility of the supplier and is not covered a covered benefit. Extensive maintenance on purchased equipment requiring an authorized technician may be billed by the supplier as a repair.

Installation of rented or purchased equipment is covered in most situations. Construction as part of installation is not covered. Installation of DME also requires an invoice. If charges are going to exceed $25, a prior authorization is required. For more information about requesting a prior authorization, please see the Verifying Eligibility and Prior Authorization section of this manual.

Medical Supply Benefits and Limitations

DME services are covered for in-home use. Some DME services (purchase or rental) are covered in our nursing facilities, swing bed facilities, psychiatric residential treatment facilities (PRTF), head injury facilities (HI), rehabilitation facilities, and hospitals.

Note: If the facility receives a per diem rate for a member, the DME services are considered included in the per diem and are the responsibility of the facility.

If it is medically necessary to dispense more than the amount allowed for a particular item, document the reason for additional units on a Certificate of Medical Necessity form and attach to your claim.

Chapter 8: Hospice End of Life

Advance Directives

We expect our network providers, such as you to comply with federal legislation (OBRA 1990, Sections 4206 and 4751) concerning advance directives.

Provide written information to every adult member receiving medical care. The information pertaining to the right to :

- Make decisions concerning his or her own medical care
- Accept or refuse medical or surgical treatment
- Make advanced directives
- Have those advanced directives honored

Incapacitated Members

A member may be admitted to a facility in a comatose or otherwise incapacitated state, and be unable to receive information or articulate whether he or she has an advance directive. If this is the case, families of, surrogates for, or other concerned persons of the incapacitated individual must be given the information about advance directives. If the incapacitated member is restored to capacity, the facility must provide the information about advance directives directly to him or her even though the family, surrogate or other concerned person received the information initially. If an member is incapacitated, otherwise unable to receive information or articulate whether he or she has an advance directive, this must note this in the medical record.

Mandatory Compliance with the Terms of the Advanced Directive

When a member, relative, surrogate, or other concerned/related person presents a copy of the member's advance directive to the facility, the facility must comply with the terms of the advance directive to the extent allowed under state law. This includes recognizing powers of attorney.

Hospice

A statement signed by the PCP certifying that beneficiary member has a medical prognosis with a life expectancy of six months or less if the illness runs its normal course is required for hospice care.

Election statement

A revocable statement signed by a member or his/her legal representative which is filed with a particular hospice and consists of:

- Identification of the hospice selected to provide care to the member
- Acknowledgement that the member has been given a full explanation of hospice and the palliative rather than curative nature of hospice care
- Acknowledgement by the member that our payment for services other than those stated above related to the terminal illness or related conditions are waived by the election of hospice care, with the exception of those HCBS services that cannot be provided by the hospice provider

Note: Hospice providers are responsible for the coordination of all services and communication with our community-

based case manager. Evidence of coordination with other Care Coordinator should be reflected in the hospice plan of care.

Providers are required to enter hospice assignment or revocation information through the website. Each provider must keep a hard copy of the hospice assignment or revocation information on file. The hospice assignments must be entered within 5 calendar days of the date the beneficiary signed the election statement.

Election statements are submitted via the Iowa UHCCommunityPlan.com page. When submitting a new hospice election, providers use the Verify/Add/Change LTC Facility button on the Hospice Election Assignment window to enter the NPI information for members who reside in a nursing facility or hospital. Help windows are available from the toolbar for each hospice window. Contact Customer Service at 800-933-6593 or 785-274-5990 for questions or help using the website.

As a reminder, there is a five day grace period starting at the time of admission or election to hospice care during which the provider must submit a hospice election through the website. The website guides the user through the process of electronic submission. If the entry date of the hospice election is beyond the five day requirement, the provider must fax the election statement and a written request to the hospice coordinator at 800-913-2229. The election statement must include the following information:

- Provider name and number.
- Facility or hospital name and address if billing for room and board charges
- Effective date of the election period
- Signature of the member or his/her legal representative
- Member Medicaid ID number
- Member date of birth

Palliative Care

The provision of patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

Note: In accordance with 42 Code of Federal Regulation (CFR) 418.569 (b) The hospice must ensure that each patient and the primary care giver (s) receive education and training provided by the hospice as appropriate to their responsibilities for the care and services identified in the plan of care.

8.2 Duration of Coverage

- Hospice Coverage must be certified by a physician and coverage includes two 90 day episodes of care and unlimited subsequent 60 day episodes of care.
- Election to receive hospice care will be considered to continue through the initial election period and any subsequent election periods without a break in care, under the original signed election statement, as long as the beneficiary remains in the care of the hospice and does not revoke the election.
- A beneficiary may revoke hospice care at any time he or she chooses by filing a document with the hospice. This document must include a signed statement that the beneficiary revokes the election of Medicaid coverage of hospice care and the date the revocation is effective.
- Upon revoking the election of Medicaid coverage of hospice care, the beneficiary resumes coverage of the benefits waived when hospice care was elected.
- A beneficiary may change the designation of a particular hospice from which he or she elects to receive hospice care only once.

8.3 Forms

The following forms will be available on the Iowa UHCCommunityPlan.com page on Jan. 1, 2016:

Forms which must be kept on file at the hospice:

- CERTIFICATION STATEMENT - certifies the beneficiary is terminally ill.
- ELECTION STATEMENT - verifies the beneficiary has elected hospice care and the name of the hospice which will provide care.
- REVOCATION STATEMENT - shows the beneficiary has revoked hospice care and is entitled to regular benefits.
- CHANGE OF HOSPICE - shows the beneficiary has elected another hospice to provide care.
- NOTIFICATION OF DEATH - verifies the beneficiary's date of death.

All forms must include the following information:

- Beneficiary name
- Beneficiary date of birth
- Beneficiary Medicaid ID number
- Hospice provider's name and ID number
- Hospice start of care/effective date
- Beneficiary's or legal representative's signature
- Date of signature

8.4 Services

The following services must be provided:

Core Services

A hospice must ensure that all the core services are provided by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. Core services include nursing services, medical social services, and counseling in accordance with 42 CFR 418.64. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice must maintain professional, financial, and administrative responsibility for the services and must ensure that the qualifications of staff and services provided meet all requirements.

Counseling Services

Counseling services must be available to both the patient and family to assist in minimizing the stress and problems that arise from the terminal illness and related conditions and the dying process. Counseling services must include, but are not limited to, the following: dietary, spiritual, and bereavement counseling.

- Dietary counseling must be provided by a registered dietician to address and ensure the dietary needs of the patient are met.
- Spiritual counseling must include an assessment of the patient and family's spiritual needs, provision of spiritual counseling to meet those needs in accordance with the patient and family's acceptance of this service, and in a manner consistent with the patient and family's beliefs and desires. Reasonable efforts should be made to facilitate visits from local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs.
- Bereavement counseling must include the provision of bereavement services furnished under the supervision of a qualified professional with experience or education in grief or loss counseling. The hospice provider must make bereavement services available to the family and other individuals in the bereavement plan of care up to one year following the death of the patient. Bereavement counseling also extends to residents of a NF, skilled NF, or ICF/IDD when appropriate and identified in the bereavement plan of care.

Continuous Home Care

- Continuous home care is covered when it is provided to maintain an individual at home during a medical crisis. A period of crisis is a time when a patient requires continuous care (primarily professional nursing care) to achieve palliation or the management of acute medical symptoms.
- Nursing care must be provided by an RN or a licensed practical nurse (LPN). The RN/LPN must be providing care for more than half of the period of care.
- A minimum of eight hours of care must be provided during a 24-hour day which begins and ends at midnight. The care need not be continuous (such as, four hours can be provided in the morning and another four hours can be provided in the evening of that day). Homemaker and home health aide services can also be provided to supplement the nursing care.

Drugs

- All drugs related to the terminal illness of the patient are covered by the hospice program and are included in the daily rate.

Home and Community Based Services

- Beneficiaries receiving hospice services may also be eligible to receive services through the HCBS program. However, HCBS cannot duplicate services being rendered by the hospice provider.
- To ensure services are not duplicated and the hospice beneficiary is receiving the quality of care that he or she is entitled to, UHC may ask for written care plans from hospice and HCBS providers. Hospice is the coordinator of all care services that the hospice beneficiary receives. When a beneficiary is admitted to hospice services while receiving targeted case management (TCM) services, providers do not need to obtain PA for TCM services. Care coordination provided through the hospice benefit and TCM are separate and distinct services and are not duplicative. Evidence of coordination with other case managers should be reflected in the hospice plan of care.

Home Health Aide and Homemaker Services

These services must be available and adequate in frequency to meet the needs of the beneficiary. A registered nurse (RN) must visit the home site at least every two weeks when aide services are being provided. This visit must include a written assessment of the aide service. Written instructions for patient care are prepared by the RN. Duties include personal care, ambulation and exercise, household services essential to health care at home, assistance with medications that are ordinarily self-administered, reporting changes in the patient's condition and needs, and completing appropriate records. The hospice must be the sole provider of these services.

Inpatient Care

- **Hospice must notify UnitedHealthcare of any hospital admission.** Care must be available for pain control, symptom management, and respite purposes. It may be provided in a participating hospice inpatient unit, hospital, or nursing facility the hospice has contracted with that meets the special hospice standards regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. General inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management which cannot be provided in other settings.
- Once the member has elected hospice services, the expectation is that hospice will coordinate all services and will provide education to the member, family, and caregivers regarding unforeseen changes in the beneficiary's health condition.
- The hospice must assume responsibility for professional management of the resident's hospice services, in accordance with the hospice plan of care and the hospice conditions of participation, and make any arrangements necessary for hospice-related inpatient care in accordance with 42 CFR 418.112.

Medical Social Services

These services must be provided by a licensed social worker, under the direction of a physician. Social work activities include assessing client needs, securing resources to meet those needs, working with family issues, problem-solving intervention, and supportive one-on- one work with beneficiaries.

Nursing Services

The hospice must provide nursing care and services by or under the supervision of an RN. Nursing services must be

directed and staffed to ensure the nursing needs of patients are met. Patient care must be specified in a plan of care and must be provided in accordance with licensing standards.

Physical Therapy, Occupational Therapy, and Speech Language Pathology

These services are provided for the purposes of symptom control or to enable the beneficiary to maintain activities of daily living and basic functional skills. When provided, they must be offered by persons either appropriately certified or under the supervision of one appropriately certified in the respective discipline to offer that service. Therapy services must be offered in a manner consistent with accepted standards of practice.

Physician Services

- Basic payment rates for hospice are designed to reimburse the hospice for the costs of all covered services related to the treatment of the beneficiary's terminal illness, including the administrative and general supervisory activities performed by physicians who are employees of or working under arrangements made with the hospice. These functions are performed by the physician serving as the medical director and the physician member of the hospice interdisciplinary group. This includes participation in the establishment, periodic review, and updating of plans of care, supervision of care and services, and establishment of governing policies. The costs for these services performed by the physician are included in the reimbursement rates for the four levels of care.
- Claims submitted by any physician providing direct patient care to a hospice-enrolled beneficiary will be reimbursed. Direct patient care services provided by a hospice physician are allowable charges that must be billed under the physician's provider number.

8.8 Hospice Coverage in Nursing Facilities

- **UnitedHealthcare will reimburse room and board services for beneficiaries (Medicaid and Medicaid/Medicare eligible) who live in NFs.** Reimbursement will be provided when a beneficiary elects hospice benefits and the hospice and facility have a written agreement under which the hospice is responsible for the professional management of the beneficiary's hospice care and the facility agrees to provide room and board. The room and board component of hospice coverage is a -covered service. Payment is made to the hospice for room and board, in addition to routine home care or continuous home care, for those who have elected hospice coverage. The Hospice is responsible for payment to the Nursing Facility for room and board.
- **The NF or ICF/ID must not bill during the hospice-election time frame.**
  Entering NF or ICF/ID dates of service (DOS) which overlap with hospice dates on any portion of a claim will result in the entire claim being denied.
- For UB-04 claims, the entire claim will be denied based on the header DOS. However, the edit will post on each detail regardless of whether the detail DOS is within the hospice assignment. Services provided during the dates of a beneficiary's hospice assignment must be billed separately from services provided outside the hospice assignment period.
- **Routine nursing facility supplies are content of the per diem room and board reimbursement.**
    - The hospice provider must notify DHS of any member who is receiving hospice who is admitted to a nursing facility.

8.9 Inpatient Respite Care

- **This type of care is provided only when necessary to relieve family members or other persons caring for the individual at home.** It may not be reimbursed for more than five consecutive days at a time and may be provided only on an occasional basis. A hospice patient may enter a NF which has contracted with the hospice for the purposes of receiving respite care.
- **Certification that the beneficiary is terminally ill must be completed and filed with the hospice providing care.** Hospice services must be reasonable and necessary for the palliation or management of the terminal illness and related conditions. A plan of care must be established before services are provided. To be covered, services must be designated in the plan of care.
- **In establishing the initial plan of care, the member of the basic interdisciplinary group who assesses the patient's needs must meet or call at least one other group member before writing the initial plan of care.** At least one of the persons involved in developing the initial plan of care must be a nurse or physician.
- **Other insurance is primary and must be billed first.**

8.10 Provider Requirements

- The hospice must comply with the UnitedHealthcare provider agreement and meet the Medicare conditions for participation of hospices, as noted in 42 CFR 418.
- All hospice providers must be enrolled with the state of Iowa as a Iowa Medicaid provider prior to contracting with UnitedHealthcare. This is to ensure payment of appropriate rate as determined by the state.
- All services provided by the hospice must be performed by appropriately qualified personnel. However, it is the nature of the service, rather than the qualifications of the person who provides it, that determines the coverage category of the service. Hospice services must be reasonable and necessary for the palliation or management of the terminal illness, as well as related conditions, in order to be allowed.

8.11 Hospice Limitation Audits

- Limitation audits are in place to ensure accurate payment of hospice services. will not allow reimbursement to exceed one unit per day for the following per diem hospice level of care codes: T2042 T2044 T2045 T2046
- Reimbursement of hospice level of care code combinations that are billable on the same date of service will remain unchanged.
- Reimbursement for level of care code T2043 is billable when a minimum of eight hours of continuous care is provided in a 24- hour period. Reimbursement will not exceed 24 hours of care per day.

8.12 Services not related to the Terminal Illness

Services for illnesses or conditions not related to the terminal illness of the beneficiary and which are usually covered are considered separately. They may be reimbursed with PA. UnitedHealthcare will pay providers for services not related to a terminal illness. All services provided that are related to the terminal illness are the responsibility of the hospice provider and should be billed to the hospice provider directly.

8.13 Transportation Services for Hospice Beneficiaries

Transportation to hospice-related services is the responsibility of the hospice provider. Medical services unrelated to hospice treatment or diagnosis may be covered if medical criteria are met.

8.14 Hospice Care for Children in Medicaid

Members receiving services reimbursed by Medicaid and Children's Health Insurance Program (CHIP) can continue medically necessary curative services, even after the election of the hospice benefit by or on behalf of children receiving services. Section 2302 of the Affordable Care Act, entitled "Concurrent Care for Children," allows curative treatment upon the election of the hospice benefit by or on behalf of children enrolled in Medicaid or CHIP.

The Affordable Care Act does not change the criteria for receiving hospice services. However, prior to enactment of the new law, curative treatment of the terminal illness ended upon election of the hospice benefit. This new provision requires states to make hospice services available to children eligible for Medicaid and Medicaid-expansion CHIP programs without terminating any other service which the child is entitled to under Medicaid for treatment of the terminal condition.

Limitations

Concurrent hospice care for children will be covered for the duration needed. An individual can elect to receive hospice care during one or more of the following election periods:

- An initial 90-day period
- A subsequent 90-day period
- Unlimited subsequent 60-day periods with appropriate physician recertification for continued hospice care

A provider must submit a copy of the physician recertification statement with their first claim for the subsequent 60-day periods. Claims will deny unless that document is submitted.

Medical Services and Concurrent Care for Children Receiving Hospice Services

Children receiving hospice services can continue to receive other reasonable and necessary medical services, including curative treatment for the terminal hospice condition.

- Prior authorization is only required if the services rendered are on the UnitedHealthcare prior authorization list.
- Hospice providers will be responsible for coordinating all services related to the hospice diagnosis and assisting non-hospice providers to obtain authorization when required on UnitedHealthcare's Prior Authorization list.
- Hospice providers will be responsible for all durable medical equipment, supplies, and services related to the hospice diagnosis.
- Non-hospice providers must first communicate and coordinate with hospice providers regarding needed services or procedures prior to rendering concurrent care for children.
- Non-hospice providers must bill hospice first to receive a payment or denial for the service provided.
- If payment is denied by hospice, non-hospice providers can submit the claim to UnitedHealthcare for payment.

Hospice patients (0 through 20 years of age) can receive the services identified below as long as the services are not duplicative of services provided by the hospice facility.

- Case management services when provided and billed by an ARNP enrolled in
- Technology Assisted (TA) waiver program attendant care services

Note: Hospice providers will continue to be responsible for all durable medical equipment and supplies

Chapter 9: Health Homes

We implement a Health Home model which builds upon the primary care physician –led medical home model. These health homes are designed to help our qualifying Medicaid members who primarily qualify due to chronic, complex life conditions that require extensive care management to allow them to continue to functioning in the community of their choice. We contract with motivated medical practices willing to implement this person-centered approach with the support of our care coordination. Through this continuum, multi-faceted approach we work to maintain or improve each member's community living by:

- Improving or preventing further progression of medical, social and behavioral health issues associated with member's complex conditions
- Encouraging quality of life while respecting member dignity, culture, and personal choice
- Nurturing member and provider relationships
- Improve prevention and access to services
- Coordinating transparent care planning through online tools accessible by the care team, including the member
- Using education and planning to reduce otherwise avoidable emergency room visits and admissions
- Accommodating any necessary transitions between service providers and levels of care

Our Health Homes are designed to care for children and adult members who qualify by having two chronic medical conditions. Members who may also qualify have been diagnosed with asthma or diabetes and are at risk for developing a secondary chronic condition such as:

- Coronary Artery Disease
- Major Depressive Disorder
- Hypertension
- Obesity
- Substance use disorder

Our Integrated Health Homes are designed to care for children and adult members who qualify by having Severe and Persistent Serious Mental Illness or a serious emotional disturbance (SED). These are members with psychiatric illnesses involving complex symptoms that require ongoing treatment and management and most often varying types and dosages of medication and therapy. Some commonly seen diagnoses
associated with this complexity include:

- Bipolar Disorder
- Obsessive-Compulsive Disorder
- Personality disorder sever enough to prevent functioning
- Schizophrenia Spectrum and Other Psychotic Disorders
- Major Depressive Disorder that resists treatment and impacts ability to function

In some geographic areas we implement an Accountable Care Community approach to improve community health. We work toward optimizing resources while reducing service redundancy by utilizing collaborative partnerships involving medical, social, business and community representation. This approach also incorporates the primary care physician –led Medical Home model

which empowers members to actively manage their personal health.

As a network provider, you may be invited to become involved in this team approach through referrals to care for one or more of our members. To see more information about our health homes and accountable care communities visit UHCCommunityPlan.com > For Health Care Professionals > Iowa > Billing and Reference Guides > Our Care Coordination. For additional information about Iowa Medicaid health homes, please go to http://dhs.iowa.gov/ime/providers/enrollment/healthhome.

Chapter 10: Long Term Services and Supports/Home and Community Based Services (HCBS)

The HCBS Program is a Medicaid long-term delivery system which fully integrates traditional physical health, behavioral health and nursing facility based services, with Home and Community Based Services (HCBS). This integration ensures a full continuum of services for Medicaid members through a Managed Care Organization (MCO). The state of Iowa now fully integrates these services into the MCO and no longer directly administrates these valuable services for the HCBS programs outlined in the section below.

The Home and Community Based Services (HCBS) programs are designed to meet the needs of members who would otherwise require care in a medical institution. The variety of services are designed to provide the most integrated means for maintaining the overall physical and mental condition of those members with the desire to live outside of an institution. All HCBS services require prior authorization through the plan of care (POC) process.

The collective goals of the HCBS Program include:

- Integrated, whole-person care.
- Preserving or creating a path to independence.
- Alternative access models and an emphasis on home and community based services.

These goals can be accomplished through the systematic process of assessment, planning, coordinating, implementing, and evaluating a member's care by care coordination. Fully integrated care coordination ensures that the member's acute/chronic physical health care, behavioral health care, and HCBS program services are provided in a seamless, cohesive, and collaborative manner reducing waste, duplication, and redundancy in services. Care coordination not only provides the member with a concierge to facilitate scheduling and service access; it also provides the recipient with an advocate that assists the member in gaining needed knowledge of services and alternatives to make the most informed decision related to health care and custodial services.

Disability Sensitivity

Each Health Plan and its Providers must comply with the Americans with Disabilities Act (ADA) (28 C.F.R. § 35.130) and Section 504 of the Rehabilitation Act of 1973 (Section 504) (29 U.S.C. § 794) and maintain capacity to deliver services in a manner that accommodates the needs of its Enrollees. Health Plans and their Providers can demonstrate compliance with the ADA by conducting an independent survey/site review of facilities for both physical and programmatic accessibility.

The Health Plan must reasonably accommodate persons and shall ensure that the programs and services are as accessible to an individual with disabilities as they are to an individual without disabilities. This will be accomplished by written policies and procedures to assure compliance while ensuring that physical, communication, and programmatic barriers do not inhibit individuals with disabilities from obtaining all Covered Services.

10.2 Overview of HCBS Programs

The state of Iowa now fully integrates the Home & Community Based Services (HCBS) for the AIDS, Brain Injury, Children's Mental Health, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. While no longer directly administering the valuable services for these HCBS programs, the state of Iowa retains authority and oversight of these programs.

Eligibility for all of the HCBS programs is determined by the state or state designees. For information on the following, please refer to the Iowa HCBS Manual available at: https://dhs.iowa.gov/sites/default/files/HCBS.pdf.

AIDS/HIV Waiver

The AIDS/HIV waiver offers services for those who have been diagnosed with AIDS or HIV.

- Adult Day Care
- Consumer Directed Attendant Care (CDAC)
- Counseling Services
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Nursing
- Respite

Brain Injury Waiver

The Brain Injury waiver offers services for those who have been diagnosed with a brain injury due to an accident or illness and be at least must be one month of age. There is no upper age limit for this waiver.

- Adult Day Care
- Behavioral Programming
- Case Management
- Consumer Directed Attendant Care (CDAC)
- Family Counseling & Training
- Home & Vehicle Modification
- Interim Medical Monitoring & Treatment
- Personal Emergency Response
- Prevocational Services
- Respite
- Specialized Medical Equipment
- Supported Community Living
- Supported Employment
- Transportation

Children's Mental Health Waiver

The Children's Mental Health waiver offers services for children who have been diagnosed with serious emotional disturbance. These are the services members may receive if there is a need for this waiver:

- Environmental Modifications & Adaptive Devices
- Family & Community Support Services
- In-Home Family Therapy
- Respite

Elderly Waiver

The Elderly waiver provides services for elderly persons. An applicant must be, at least, 65 years of age. These are the services members may receive if there is a need:

- Adult Day Care

Assisted Living

- Assistive Devices
- Case Management
- Chore
- Consumer Directed Attendant Care (CDAC)
- Home & Vehicle Modification
- Home Delivered Meals
- Home Health Aide
- Homemaker
- Mental Health Outreach
- Nursing
- Nutritional Counseling
- Personal Emergency Response
- Respite
- Senior Companion
- Transportation

Health and Disability Waiver

The Health and Disability waiver provides services for persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver. These are the services members may receive if there is a need:

- Adult Day Care
- Homemaker
- Consumer Directed Attendant Care (CDAC)
- Interim Medical Monitoring & Treatment
- Counseling
- Nursing
- Home & Vehicle Modification
- Nutritional Counseling
- Personal Emergency Response
- Home Delivered Meals

- Home Health Aide
- Respite

Intellectual Disability Waiver

This waiver provides services for persons who have been diagnosed with an intellectual disability. These are the services members may receive if there is a need for this waiver:

- Adult Day Care
- Personal Emergency Response
- Consumer Directed Attendant Care (CDAC)
- Day Habilitation
- Home & Vehicle Modification
- Home Health Aide
- Interim Medical Monitoring &Treatment
- Prevocational Services
- Respite
- Supported Community Living
- Supported Community Living Residential Based
- Supported Employment
- Nursing
- Transportation

Physical Disability Waiver

This waiver provides services for persons who have a physical disability determination. An applicant must be at least 18 years of age, but less than 65 years of age. These are the services members may receive if there is a need for this waiver:

- Consumer Directed Attendant Care (CDAC)
- Home & Vehicle Modification
- Personal Emergency Response
- Specialized Medical Equipment
- Transportation

Consumer Choices Option

The Consumer Choices Option is available under most of the HCBS waivers. It will give member control over some Medicaid dollars. Members will use these dollars to make a budget plan to meet your needs by hiring employees and/or purchasing other goods and services. The Consumer Choices Option gives members more choice, control and flexibility over their services as well as more responsibility.

More help is available if members choose this option. They will choose an Independent Support Broker who will help members make their budget and help them recruit employees. They will also work with a Financial Management Service that will manage the budget for members and pay their workers on the member's behalf.

10.4 HCBS Provider Responsibilities

HCBS Providers will provide services in accordance with the plan of care including the amount, frequency, duration, and scope of each service in accordance with the member's service schedule.

HCBS providers utilizing Electronic Visit Verification (EVV) will use the EVV system to submit claims.

10.5 Provider Credentialing/Verification

UnitedHealthcare follows the provider requirement guidelines defined in the Iowa Medicaid Provider Manual to credential nursing facility providers and providers of HCBS services.

Initial Verification/Credentialing: The initial verification/credentialing process shall include verification of required documents as outlined in the Iowa HCBS Provider Application in addition to provider requirements as defined by the state. All providers must submit the Certificate and/or Licensures as applicable to the services they are providing and each license will be verified with its issuing licensing board. Each provider will provide proof of general liability insurance that meets the minimum required amount set by the state of Iowa as applicable to the services each provider is contracting to provide. Providers will also provide proof of malpractice insurance, as applicable, as required by state guidelines.

HCBS providers are not required to maintain malpractice insurance unless required to do so per state provider requirements or applicable provider licensing requirements.

Re-Verification/Credentialing: Every 3 years, all providers will be re-verified/credentialed unless otherwise specified. This process includes meeting all initial requirements of this verification/credentialing process and may be subject to review of history of potential quality of care/quality of service concerns within the re-credentialing cycle.

In the event an applicant fails to meet the verification/credentialing requirements, the applicant will be denied and notified in writing. An applicant has the right to appeal an adverse decision within 30 days of notification. Applicants have the right to be notified of the credentialing decision within 60 calendar days of the decision.

Electronic Visit Verification Requirements

The Electronic Visit Verification (EVV) system is an external scheduling and tracking system used by HCBS providers to manage their work based on authorizations that are approved by United. The system verifies that the services were delivered and allows for generation of claims for those services to be submitted after completion. Some of these services may be non-medical (atypical) in nature like Meals for Wheels or for construction work like installing a shower bar to hopefully prevent the member from falling. Typical services are provided with assistance with activities of daily living (ADL).

10.6 Home and Community Based Services:

A summary of the HCBS services, including benefit limitations, unit definitions and billing codes may be found in the Iowa HCBS Manual available at https://dhs.iowa.gov/sites/default/files/HCBS.pdf.

10.7 Claim Filing Information for Nursing Facilities

Nursing facilities should use the UB-04 claim form or accepted electronic equivalent when requesting payment for **Nursing Facility services.** Claims may be received through your electronic data interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726. Paper claims may be submitted to the claims address indicated below. .

ICF/ID Providers should follow the billing guidelines and procedures as outlined in the state provider manual with the exception of dental service billing. The Care Coordinator who is assigned to the facility will validate those members eligible for Long Term Care (custodial) services with facility staff upon member enrollment and confirm the ongoing MCO census at minimum quarterly. Long Term Care (custodial) members residing in nursing facilities will NOT require prior authorization of the custodial stay. Facilities do not need to submit any prior authorization information when claims are submitted. **Note**: Services or supplies that are included in the per diem rate (e.g. Oxygen) do NOT require separate prior authorization.

Revenue Codes:

- 101 Custodial Care
- 120 Skilled Nursing (Revenue Code 120 should only be utilized when billed for a Medicare stay)
- 180 NF for MH (inpatient psychiatric hospital stay - 21 day limit per admission)
- 183 NF for MH home therapeutic reserve days (21 days per calendar year)
- 183 NF home therapeutic reserve days (18 days per calendar year)
- 185 NF hospital reserve days (10 day limit per admission)
- 189 Non-covered days
- Annual Vaccination – Influenza
  Revenue Code 0636 and CPT Code, 90654, 90656, 90660, 90662,Q2034, Q2035, Q2036, Q2037, Q2038, or Q2039
- Annual Vaccination Administration – Influenza
  Revenue Code 0771 and HCPC Code G0008

Nursing Facility Bill Types:

Enter the three-digit number specific to the type of claim

1st digit:

2 – Skilled nursing

6 – Intermediate care

2nd digit:

If the 1st digit is a 2, the second digit is:

1 - Inpatient

If the 1st digit is a 6, the second digit is:

5 - Level 1

6 - Level 2

3rd digit:

0 – Nonpayment/zero claim

1 – Admit through discharge claim

2 – Interim – first claim

3 – Interim – continuing claim

4 – Interim – last claim through date to discharge date

7 – Replacement of a prior claim

8 – Void/Cancel of a prior claim

Nursing Facilities Services:

The services outlined below are included in the nursing facility per diem and cannot be billed or paid separately. For a detailed list of services and supplies included in the nursing facility per diem, please reference the state Iowa Department of Human Services Nursing Facility and the Intermediate Care Facilities for the Intellectually Disabled Manuals.

- Licensed nursing supervision 24 hours per day, 7 days week
- Specialized rehabilitation services
- Routine medical equipment and supplies including all durable medical equipment, including oxygen and all oxygen related supplies
- Physical, speech, occupational, respiratory and all other therapies
- Transportation
- Over the counter medications provided on an as-needed or PRN basis are part of the per diem
- Dietitian services
- Assistance with daily living skills
- Miscellaneous services and supplies considered routine to attain and maintain the highest practicable physical and psychosocial well-being in accordance with the plan of care

Admission, Transfer, and Discharge Rights of Residents in Adult Care Homes

Each licensee, administrator, or operator shall comply with the state regulation in the admission, transfer and discharge rights of residents in adult care homes.

Patient Client Participation

Client participation is the amount of a member's income, as determined by IDHS, to be collected each month.

Nursing facilities are expected to collect patient client participation amounts from the members and may utilize appropriate legal actions to collect these amounts.

In the event a member fails to pay his or her patient client participation y, the nursing facility may refuse to continue to provide services. The nursing facility must demonstrate to UnitedHealthcare that it has made a good faith effort to collect payment and must notify the member's care coordinator prior to discharge. The member should receive appropriate notice and education regarding the consequence s of non-payment of patient liability, including potential disenrollment from the program.

NPI Filing Requirements

A National Provider Identifier (NPI) is required for all Iowa medical providers. All provider identifiers must be valid NPI numbers. This includes billing, servicing, rendering, attending, operating, referring and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

Paper Claim Submission Address

Initial paper claims and corrected paper claims should both be submitted to this address.
UnitedHealthcare Community Plan
P.O. Box 5220
Kingston, NY 12402-5220

Provider Claim Reconsideration Requests

If you have questions relating to claims payments please contact Provider Services at 888-650-3462. A Provider Services Representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsidera tion, requests can be forwarded to:

UnitedHealthcare Community Plan
PO Box 5220
Kingston, NY 12402-5220

Mailing Provider Disputes

If you have filed a reconsideration request and are not satisfied with the outcome, you may file an appeal to the following address:

UnitedHealthcare Community Plan Attn: Grievance and

Appeals Dept. P.O. Box 31364
Salt Lake City, UT 84131-0364

From and Through Service Dates Bill Both Header and Detail

Box 6 of the UB "Statement covers period" from and through dates must equal the room and board units being billed in Box 46. For example, if billing for 30 units in April, the Statement Covers Period must be April 1 to April 30. For those uploading via a billing software, the statement covers from and through date maps to the EDI837I Loop 2300 DTP*434*RD8 segment which covers a date range.

Box 45 must be completed if 2 or more line items are being billed on the claim form.

Retro-Eligible Process for Filing Claims

Applies to both Behavioral Health and Medical services. **(Do not submit medical records with claims submissions.)**
To ensure timely payments upon claims submission, please note:

Paper Claim

- Indicate "Retro-Eligible" in Form Locator 80 NTE/REMARKS (UB) or indicate at the top of the claim form.
- Attach cover letter stating member is retro-eligible.
- When documentation is required for retro-eligible authorization review, the Medical Review Unit will request that documentation from the provider.

Electronic Claim

- Indicate "Retro-Eligible" in the NTE field in electronic file (Loop 2300 for UB).
- When documentation is required for a retro-eligible authorization review, the Medical Review Unit will require that documentation from the provider via fax.

Corrected Claims

Paper Corrected Claim Resubmission Process

- Corrected claim should be mailed to:

  UnitedHealthcare Community Plan
  PO Box 5220
  Kingston, NY 12402-5220

- Write "CORRECTED" on the claim.
- Update the 3rd digit of the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- Providers may also update the third digit of the bill type to an 8 to void the claim.

- If billing with a 217 or 218 Type of Bill providers will need the original claim number. UnitedHealthcare can provide the claim number from the EDI tab in the claim screen. When billing a paper claim, the previous claim number should be entered in Box 57.

Electronic Corrected Claim Resubmission Process

UB Claims:

- Providers may submit a corrected claim electronically through their claim clearinghouse.
- Update the 3rd digit in the bill type to a 7.
- The change in bill type will flag the claim as a corrected claim.
- Providers may also update the third digit of the bill type to an 8 to void the claim.
- If billing with a 217 or 218 Type of Bill providers will need the original claim number. UnitedHealthcare can provide the claim number from the EDI tab in the claim screen. Providers should consult with their electronic claim vendor for the appropriate field to enter the original claim number for an electronic submission.

Electronic Funds Transfer (EFT)

EFT is a method of transferring funds between bank accounts. EFT eliminates the need for paper checks and improves cash flow timing. Providers may request EFT by submitting the EFT Form which can be found on UHCCommunityPlan.com or requested through your Provider Advocate. Providers are encouraged to return EFT forms as soon as possible to allow adequate time for processing.

10.8 Claim Filing Information for HCBS Providers

HCBS program codes and limits apply to all Home and Community Based Services. Covered services, service definitions, units and benefit limitations are consistent with the Iowa Department of Humans Services (IDHS) HCBS Provider Manual. Please reference the IDHS HCBS manual for specific service definitions.

HCBS providers should use the CMS 1500 claim form or an accepted electronic equivalent when requesting payment for HCBS services. Claims may be received through your Electronic Data Interchange (EDI) vendor and communicated through the OptumInsight clearinghouse (formerly Ingenix) using payer ID 87726. Paper claims may be submitted to the claims address indicated below. Providers may submit claims directly through UnitedHealthcareOnline.com

Documentation

UnitedHealthcare Community Plan follows the service documentation guidelines as defined in the Iowa Department of Human Services HCBS Provider Manual, including guidelines for electronic documentation and electronic signatures as defined in the HCBS Provider Manual. The Iowa provider manuals can be found at https://dhs.iowa.gov/ime/providers/rulesandpolicies.

Client Obligation

The state will communicate each member's client obligation, as applicable, to UnitedHealthcare Community Plan via the member enrollment file UnitedHealthcare receives from the state. Providers who have been assigned the client obligation should not reduce the billed amount on the claim by the client obligation amount because it will be deducted as claims are processed.

UnitedHealthcare Community Plan will make every effort to assign the client obligation, as applicable, to the provider that was historically assigned the client obligation by the state. The client obligation will typically be assigned to a single provider (if a single provider's services will offset the client obligation amount). In addition, we will make every effort to assign the client obligation to a single service, when possible, if the total services provided each month for that service are sufficient of offset the monthly client obligation amount. In the absence of state direction, we will assign the client obligation to the provider that has the largest cost of services for the month.

On a monthly basis, a notification letter will be mailed to each member and to each provider for whom client obligation has been assigned.

Date Span Billing

Providers may bill for date spans as they have in the past.

- Providers are currently going to be able to bill non-consecutive days with date span billing.
- Providers cannot overlap billed date spans, otherwise the claims may experience possible duplication edits and/or other claim errors.

On occasion, it may be necessary for United to split an authorization for the month due to a current unit limitation in our system. If that is the case, Providers will need to bill date spans consistent with the authorization date spans.

- Providers will experience claim payment issues if billing for services across multiple authorization date spans.

Third Party Liability

Please see section 11.12 Claims for TPL claim submission rules.

NPI Filing Requirements

A National Provider Identifier (NPI) is required for all Iowa medical providers, and all provider identifiers billed on claims must be valid NPI numbers.

This includes billing, servicing, rendering, attending, operating, referring, and prescribing a service. If a field is optional, you do not have to include an NPI number; however, if something is submitted in optional fields, it must follow the NPI requirements.

UnitedHealthcare requires providers to obtain an NPI only in those instances in which an NPI is required by the State for the services offered by the provider. If the State has not required a provider NPI, UnitedHealthcare will treat those providers as atypical providers for whom an NPI is not required.

Corrected Claims

To file a corrected claim **Electronically** through the Front End Billing option:

- Create a new day claim through the Front End Billing option.
- Enter the United Original Claim Number (from the remittance advice) in the Timely Filing Override ICN Field.
- Provide all information that is correct for the claim and submit it as a new claim.
- The claim will be identified as a corrected claim due to the presence of the UnitedHealthcare Original Claim Number.

To file a corrected claim via **Paper:**

- Providers may also file corrected claims via paper by sending corrected claims to:
- Write "CORRECTED" on the claim and add the original claim number in Box 22 of the 1500 form

To correct an **EVV/AuthentiCare claim**:

- If the EVV claim was already released, providers should follow one of the above corrected claim processes (Front End Billing or Paper)

Provider Claim Reconsideration Requests

If you have questions relating to claims payments please contact Provider Services at 888-650-3462. A Provider Services Representative may be able to assist you without requiring additional administrative work. If you are requested to submit a payment reconsideration, requests can be forwarded to:

UnitedHealthcare
P.O. Box 5270
Kingston, NY 12401

Mailing Appeals

If you have filed a reconsideration request and are not satisfied with the outcome, you may file an appeal to the following address:

UnitedHealthcare Community Plan Attn: Grievance and Appeals Dept. P.O. Box 31364
Salt Lake City, UT 84131-0364

Electronic Funds Transfer (EFT)

EFT is a method of transferring funds between bank accounts. EFT eliminates the need for paper checks and improves cash flow timing. Providers may request EFT by submitting the EFT Form which can be found on UHCCommunityPlan.com or requested through your Provider Advocate.

Providers are encouraged to return EFT forms as soon as possible to allow adequate time for processing.

10.9 Subrogation and Coordination of Benefits

See section 11.12 for TPL claim processing submission.

10.10 Care Coordination

Care Coordination for Nursing Facility Residents

Care Coordinators are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care/service plan development within 30 days of member assignment and with significant changes, annual reassessments
- Assisting with transition management following inpatient admissions
- Facilitating integration with Optum Behavioral Health as needed to support the member and family

Community Based Case Management for HCBS Program Members

Community based case managers are responsible for:

- Completing a comprehensive assessment that includes the member's functional ability, physical and behavioral health conditions, available informal supports, environmental considerations, social assessment as well as member and family preferences
- Initial assessment and care/service plan development within 30 days of member assignment, contacts quarterly and with significant changes, annual reassessments
- Assisting with transition management following inpatient admissions
- Supporting and educating on chronic condition management
- Facilitating community resource linkages
- Submitting the authorization for HCBS services. The provider receives written confirmation of the authorization and services to be delivered
- Contacting contact HCBS members quarterly at minimum and with significant changes in condition; face-to-face visits occur every quarter at minimum

- Contacting HCBS members face to face quarterly at a minimum with significant changes in condition

Additional Information Regarding Care Coordination for the HCBS Waiver Programs

UnitedHealthcare's Care Coordinators will act as a resource to the Targeted Case Managers, case managers, and IHHs and the member/support team and will complete internal assessments and drive the integrated plan of care.

One of the key tasks a Care Coordinator can assist with is helping the member and/or the Targeted Case Manager, case managers, and IHHs navigate the managed care system (for example: obtaining DME and assisted services, coordinating complex medical or behavioral health care needs, and making sure that covered benefits are acquired appropriately).

Until each HCBS member is transition to the MCO Community Based Case management (by Dec. 31, 2016 at the latest) Targeted Case Managers, case managers, and IHHs will continue to complete tasks associated with the five areas CMS has outlined as Targeted Case Management:

- Assessment
- Development of a plan of care (PCSP)
- Referral and related activities
- Monitoring and following up
- Contacts

UnitedHealthcare's Care Coordinators will collaborate with our members and their Targeted Case Managers to:

- Participate in person centered support planning either in person at the meeting (if invited) or providing resources before and after meeting
- Conduct member assessments and visits in the member's home or intermediate care facility setting
- Develop an integrated plan of care for each member
- Facilitate access to needed services/supports for members
- Coordinate transitions of care between institutions, facilities, different HCBS programs, and/or service providers as needed.

Chapter 11: Claims

11.1 Claims Billing Procedures

To submit claims (within 90 days of service) at electric fund transfer payments and statements online at UnitedHealthcareOnline.com > secure logon > Claims & Payments. (Use payor ID 87726.)

For more information about electric data exchange including clearinghouses, visit UnitedHealthcareOnline.com > Tools & Resources > EDI Education for Electronic Transactions

If a claim must be submitted on paper, you should send claims to the following address:

United Healthcare Community Plan Claims
P.O. Box 5220
Kingston, NY 12402-5220

11.2 Claims Format

Paper Claims for medical or hospital services must be submitted using the standard Centers for Medicaid and Medicaid Services (CMS) Form1500, UB04, 5010 format or respective electronic format.

11.3 Claim Processing Time

Clean claims are paid within 30 business days of receipt, unless otherwise specified in you network agreement contract.

11.4 Tax Identification Numbers/Provider IDs

Please submit standard transactions using your tax identification number and your National Provider Identification (NPI). To ensure proper claims adjudication, please use the ID that best represents the Health Care Professional that performed the service.

Importance and Usage of EDI Acknowledgment/Status Reports

Software vendor reports only show that the claim left the provider's office and either was accepted or rejected by the vendor. Your software vendor report **does not** confirm claims have been received or accepted at clearinghouse or by the Health Plan. Acknowledgement reports show you the status of your electronic claims after each transmission. Analyzing these reports, you will know if your claims have reached the Health Plan for payment or if claim(s) have been rejected for an error or additional information.

Providers **MUST** review their **reports, clearinghouse acknowledgement reports** and the Health Plan's status reports to eliminate processing delays and timely filing penalties for claims that have not reached the Health Plan.

How do I get these reports?

Your software vendor is responsible for establishing your connectivity to our clearinghouse **OptumInsight at OptumInsight.com/connectivity**, and will instruct you in how your office will receive Clearinghouse Acknowledgement Reports.

How do I correct errors?

If you have a claim that rejects, you can correct the error and retransmit the claim electronically the same day, causing no delay in processing. It is very important that clearinghouse reports are reviewed and worked after each transmission. These reports should be kept if you need documentation for timely filing later.

IMPORTANT: If a claim is rejected and corrections are not received by the Health Plan within 90 days from date of service or EOB from primary carrier, the CLAIM WILL BE CONSIDERED LATE BILLED and denied as not allowed for timely filing.

Electronic Payments & Statements

We use this Optum platform to manage electronic payments. You can access the following functions:

- View your electronic payments
- Receive confirmation of successful deposits into your bank account (or when a successful check is issued)
- View electronic remittance advices that you can print

For registration and additional information visit UnitedHealthcareOnline.com > Electronic Payments and Statements.

11.5 Span Dates

Exact dates of service are required when the claim spans a period of time, except for HCBS services. Please indicate the specific dates of service in Box 24 of the CMS1500, Box 45 of the UB04, or the Remarks field. This will eliminate the need for an itemized bill and allow electronic submission.

11.6 Effective Date/Termination Date

Coverage will be effective on the date the member is effective with our health plan, as assigned by the Health Care Authority. Coverage will terminate on the date the member's benefit plan terminates with us.

If a portion of the services or confinement take place prior to the effective date, or after the termination date, an itemized split bill will be required. For , if a member is covered by us upon the date of admission, termination does not occur until discharge.

Please be aware that effective dates for members are frequently revised, as individual members re-verify their Medicaid eligibility e. You should verify eligibility at each visit, to ensure coverage for services.

11.7 Overpayments

Overpayments
If you identify an overpayment of a claim, you must refund the overpayment within thirty (30) days. Send the credit balance to:

UnitedHealth Group Recovery Services
P.O. Box 740804,
Atlanta, GA 30374

Please include the appropriate documentation that explains the overpayment, including member ID, check number, date of services and amount paid.

11.8 Reconsideration Requests

Reconsiderations

You can electronically re-submit claim reconsideration through Optum Cloud Dashboard. Attachments are accepted for consideration. Visit UnitedHealthcareOnline.com > Optum Cloud Dashboard > and log in. To mail a claim reconsideration, a form is available at UHCCommunityPlan.com > For Healthcare Professionals > TX > Provider Forms > Claim Reconsideration From.

A copy of the claim and supporting documentation will be required for review.

It is important to mark the claim as a "Payment Reconsideration" to make sure the claim is routed to the appropriate area for review. An indication of "appeal" may result in the claim being forwarded to the Member Appeal area of the Health Plan and potential delays in the claim review process.

11.9 Provider Complaints and Claims Payment Disputes

Provider Complaints

We resolve complaints within 30 calendar days of receipt. We will respond fully and completely to your complaints in writing.

To file a complaint, the physician should send their complaint in writing and send it via regular mail to:

UnitedHealthcare
Attention: Formal Complaints and Claim Appeals
PO Box 31364
Salt Lake City, UT 84131-0364

Provider Claims Adjustment Request

You may call Provider Services at 888-650-3462 and select the correct prompts, including opting to speak with a Provider Phone Representative (PPR). The PPR is trained to address your inquiry and handle initial claim related calls.

We may make claim adjustments without requesting additional information from you. You will see the adjustment on the Provider Remittance Advice. When additional or correct information is needed, we will ask you to provide it.

If you disagree with a claim adjustment or our decision not to make a claim adjustment, you can appeal the determination (see Formal Claim Appeals).

Provider Formal Claim Appeals

Formal claim appeals are appeals of any payment decisions that DO NOT involve our determination of medical necessity. Formal claim appeals may be made for claims that are:

- Denied in entirety
- Denied in part
- Paid at a rate asserted to be inconsistent with contracted rates

Some of the common reasons for formal claim appeals include, but are not limited to, disputes concerning the following reasons:

- Failure to obtain required prior authorization
- Untimely submission
- Reimbursement disputes

All formal claim appeals must be filed within 30 days of the date of the UnitedHealthcare Community Plan of Iowa remittance advice.

The form for submitting a Formal Claims Dispute can be found on our provider web site at UnitedHealthcare Community Plan. Formal Claims Disputes should be mailed to:

UnitedHealthcare Community Plan
P.O. Box 31364
Salt Lake City, UT 84131

Or fax your Claims Dispute to: 801-994-1082

A formal claim dispute is a comprehensive review of the disputed claim or claims, and may involve a review of additional administrative or medical records by a clinician or other personnel. UnitedHealthcare generally completes the review within 30 calendar days. However, depending on the nature of the review, a decision may take up to 60 days from the receipt of the claim dispute. **Please allow 10 business days from this submission to enable us to begin processing the review before calling our Provider Services call center to request a status update**.

If you are appealing a claim that was denied because filing was not timely, for:

- Electronic claims: include confirmation that UnitedHealthcare or one of its affiliates received and accepted your claim.
- Paper claims: include a copy of a screen print from your accounting software to show the date you submitted the claim.

If you disagree with the outcome of the claim appeal, an arbitration proceeding may be filed.

11.10 The Correct Coding Initiative

The Health Plan performs coding edit procedures, based primarily on the CCI (Correct Coding Initiative) and other nationally recognized and validated sources.

The edits basically fall into one of two categories:

1. Comprehensive and Component Codes.

Comprehensive and component code combination edits apply when the code pair(s) in question appears to be inclusive of each other in some way. This category of edits can be further broken down into subcategories that explain the bundling rationale in more detail. Some of the most common causes for denials in this category include:

- Separate procedures. Codes that are, by CPT definition, separate procedures should only be reported when they are performed independently, and not when they are an integral part of a more comprehensive procedure.
- Most extensive procedures. Some procedures can be performed at different levels of complexity. Only the most extensive service performed should be reported.
- With/without services. It is contradictory to report code combinations where one code includes and the other excludes certain other services.
- Standards of medical practice. Services and/or procedures that are integral to the successful accomplishment of a more comprehensive procedure are bundled into the comprehensive procedure, and not reported separately.
- Laboratory panels. Individual components of panels or multichannel tests should not be reported separately.
- Sequential procedures. When procedures are often performed in sequence, or when an initial approach is followed by a more invasive procedure during the same session, only the procedure that achieves the expected result should be reported.

2. Mutually Exclusive Codes.

These edits apply to procedures that are unlikely or impossible to perform at the same time, on the same patient, by the same physician. There is a significant difference in the processing of these edits versus the comprehensive and component code edits.

CCI guidelines are available in paper form, on CD ROM, and in software packages that will edit your claims prior to submission. Your CPT and ICD-10 vendor probably offers a version of the CCI manual, and many specialty organizations have comprised their own publications geared to address specific CCI issues within the specialty. CMS's authorized distributor of CCI information is the U.S. Department of Commerce's National Technical Information Service, or NTIS. They can be reached at 800-553-NTIS (6847), or on the Web at ntis.gov.

11.11 Immunizations Billing

The Health Plan must provide for administration of all mandated childhood immunizations according to the recommended schedule of the Advisory Committee on Immunization Practices (ACIP) standards, a current copy of which is included on UHCCommunityPlan.com.

All vaccines for members will be provided through the State of Iowa, which will distribute vaccines to providers who are willing to participate in the vaccine program.

The cost of the vaccine will not be billed to the Health Plan. The only cost associated with immunizations to be reimbursed under the Policy shall be the cost to administer the vaccine. Vaccines may be administered by network providers, including school-based nurses, by a non- participating provider to whom UnitedHealthcare has referred the member, or by the State of Iowa. Providers administering State of Iowa vaccines must agree to participate in the state's Immunization Registry. UnitedHealthcare must reimburse these providers on a fee-for-service basis for the cost of administering any immunizations they provide to members. Other non-routine immunizations, such as influenza vaccine or tetanus boosters provided pursuant to an injury, shall be covered as any other covered service. UnitedHealthcare shall submit a monthly report containing a list of providers, their contact information, claimant information and corresponding vaccine administrations to the State of Iowa.

11.12 Subrogation and Coordination of Benefits

Our benefits contracts are subject to subrogation and coordination of benefits (COB) rules.

Subrogation - We reserve the legal right to recover benefits paid for a member's health care service when those services are related to an accident or workman's comp.

COB - Coordination of benefits is administered according to the member's benefit contract and in accordance with applicable statutes and regulations. Please update your office records with the patient's other insurance carrier information, at each visit. When billing claims, ensure COB information is provided on each claim form for accurate coordination of benefits and processing of payment.

Third Party Liability
UnitedHealthcare will follow the state Third Party Liability policy; if the service code billed is listed on the State's Third Party Liability Non-covered list (blanket denial list), a remittance advice or other documentation from the primary insurance is not required.

If the service is not on the State's Third Party Liability Non-covered list, providers should either bill the primary carrier to obtain the primary carrier's EOB or providers may continue to obtain other documentation historically accepted by the state for TPL purposes.

Third Party Liability – Billing Options
When a member has primary insurance, providers must file TPL information:
• If the service code billed is **not** listed on the Third Party Liability Non-covered list
  - Providers will need to file to the primary insurance and then submit the claim with the primary carrier EOB information to UnitedHealthcare, or obtain other state-approved documentation in accordance with state policy
• Providers are encouraged to bill TPL **Electronically** through the Front End Billing Option:
- Providers may enter the TPL information into the portal as defined in the Iowa Medical Assistance Program

- Professional Billing Guide
  - When billing on Paper:
    If the claim being submitted to United is a paper claim, the primary insurance remittance advice or other state-approved documentation must be attached to each paper claim
- At this time, UnitedHealthcareOnline.com does not support filing of initial claims with third party liability information.

(Important Notice: As the Iowa state Medicaid plan, the policy is always the payer of last resort.)

Chapter 12: Physician and Facility Standards and Policies

Primary Care Physicians (PCPs) are an important partner in the delivery of care and members have the freedom to seek services from any participating physician. The program does require members to be assigned to PCPs and members are encouraged to develop a relationship with a PCP who can maintain all their medical records and provide overall medical management. These relationships help coordinate care and provide the member a "medical home" that they can access to optimize their care.

Network Referrals

UnitedHealthcare Community Plan has no network limitation on referrals to any in network provider. Referrals should be made to providers, facilities and contractors who are contracted as in the UnitedHealthcare Community Plan and thereby in-network. If the member accesses care through a non-contracted provider without prior authorization, note that the services may not be reimbursed unless the service is an emergency, urgently needed, post-stabilization or out-of-area renal dialysis.

Excluded Providers

As part of ongoing efforts to ensure compliance with federal and state requirements, UnitedHealthcare performs monthly screenings of the Office of Inspector General (OIG) (www.oig.hhs.gov/fraud/exclusions.asp), the Excluded Parties List System (EPLS), and other databases for individuals or entities that have been "excluded" or "debarred" from federal programs. Individuals or entities identified as excluded or debarred as a result of these screenings will be terminated from participation in the plan, immediately, upon discovery. Payments made to "excluded" or "debarred" providers will be recovered retroactive to the date of exclusion.

12.1 Role of the Primary Care Physician

The Primary Care Physician plays a vital role as a physician case manager in the UnitedHealthcare Community Plan system by improving health care delivery in four critical areas—access, coordination, continuity, and prevention. The Primary Care Physician is responsible for the provision of initial and basic care to members, makes recommendations for specialty and ancillary care, and coordinates all primary care services delivered to our members. The Primary Care Physician must provide 24-hours/7-days coverage and backup coverage when he or she is not available.

UnitedHealthcare Community Plan expects all physicians involved in the member's care to communicate with each other and work to coordinate the member's care; this includes communicating significant findings and recommendations for continuing care.

Females have direct access (without a referral or authorization) to any OB/GYNs, midwives, physician assistants, or nurse practitioners for women's health care services and any non-women's health care issues discovered and treated in the course of receiving women's health care services. This includes access to ancillary services ordered by women's health care providers (lab, radiology, etc.) in the same way these services would be ordered by a Primary Care Physician.

UnitedHealthcare Community Plan works with members and providers to ensure that all participants understand, support, and benefit from the primary care case management system. The coverage shall include availability of 24 hours, 7 days per week access by telephone to a live voice (an employee of the Physician or an answering service) which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. **Recorded messages are not acceptable.**

12.2 Responsibilities of the Primary Care Physician

In addition to the requirements applicable to all providers, the responsibilities of the Primary Care Physician include:

- Offer access to office visits on a timely basis, in conformance with the standards outlined in the Timeliness Standards for Appointment Scheduling section of this Guide.
- Conduct a baseline examination to include a biometric screening during the member's first appointment.
- Treat general health care needs of members. Use nationally recognized clinical practice guidelines as a guide for treatment of important medical conditions. Such guidelines are referenced on UHCCommunityPlan.com.
- Consult with other appropriate health care professionals to assess and develop individualized treatment plans for enrollees with special health care needs.
- Ensure the integration of clinical and non-clinical disciplines and services in the overall plan of care for special needs members.
- Take steps to encourage all members to receive all necessary and recommended preventive health procedures in accordance with the Agency for Healthcare Research and Quality, US Preventive Services Task Force Guide to Clinical Preventive Services, http://www.ahcpr.gov/clinic/uspstfix.htm.
- Make use of any member lists supplied by the Health Plan indicating which members appear to be due preventive health procedures or testing.
- Be sure to timely submit all accurately coded claims or encounters.
- For questions related to member lists, practice guidelines, medical records, government quality reporting, HEDIS, etc., call Provider Services at 888-650-3462.
- Provide all well-baby/well-child services.
- Screen members for behavioral health problems, using the Behavioral Health Toolkit for the Health Care Professional found on our website. UHCCommunityPlan.com. File the completed screening tool in the patient's medical record.
- Coordinate each member's overall course of care.
- Be available personally to accept UnitedHealthcare Community Plan members at each office location at least 16 hours a week.
- Be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for live telephone coverage by another UnitedHealthcare participating Primary Care Physician or answering service which will immediately page an on-call medical professional so referrals can be made for non-emergency services or

information can be given about accessing services or managing medical problems during non-office hours. **Recorded messages are not acceptable.**

- Respond to after-hour patient calls within 30–45 minutes for non-emergent symptomatic conditions and within 15 minutes for emergency situations.
- Educate members about appropriate use of emergency services.
- Discuss available treatment options and alternative courses of care with members.
- Refer services requiring prior authorization to the Prior Authorization Department, Behavioral Health Unit, or Pharmacy Department as appropriate.
- Inform UnitedHealthcare Community Plan Case Management at 888-650-3462 of any member showing signs of end stage renal disease.
- Admit UnitedHealthcare Community Plan members to the hospital when necessary and coordinate the medical care of the member while hospitalized.
- Respect the Advance Directives of the patient and document in a prominent place in the medical record whether or not a member has executed an advance directive form.
- Provide covered benefits in a manner consistent with professionally recognized standards of health care and in accordance with standards established by UnitedHealthcare Community Plan.
- Provide culturally competent care and services. All providers must have a cultural competency program designed to educate and train its staff on addressing cultural and linguistic barriers to the delivery of health care services to members of all cultures.
- Document procedures for monitoring patients' missed appointments as well as outreach attempts to reschedule missed appointments.

- Transfer medical records upon request. Copies of members' medical records must be provided to members upon request at no charge.
- Allow timely access to UnitedHealthcare Community Plan member medical records as per contract requirements for purposes such as: medical record keeping audits, HEDIS or other quality measure reporting, and quality of care investigations. Such access does not violate HIPAA regulations.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.

12.3 Responsibilities of Specialist Physicians

In addition to the requirements applicable to all providers, the responsibilities of specialist physicians include:

- Provide specialty care medical services to UnitedHealthcare Community Plan members recommended by the member's Primary Care Physician or who self-refer.
- Be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for live telephone coverage by another UnitedHealthcare participating Specialist Physician or answering service which will immediately page an on-call medical professional so referrals can be made for non-emergency services or information can be given about accessing services or managing medical problems during non-office hours. **Recorded messages are not acceptable.**
- Provide the Primary Care Physician copies of all medical information, reports, and discharge summaries resulting from the specialist's care.
- Communicate in writing to the Primary Care Physician all findings and recommendations for continuing patient care and note them in the patient's medical record.
- Maintain staff privileges at a minimum of one UnitedHealthcare Community Plan participating hospital.
- Report infectious diseases, lead toxicity, and other conditions as required by state and local laws and regulations.

Medical Residents in Specialty Practice

Specialists may use medical residents in specialty care in all settings supervised by fully credentialed UnitedHealthcare Community Plan specialty attending physicians.

24-Hours, 7-Days-a-Week Coverage

Primary Care Physicians and obstetricians must be available to members by telephone 24 hours a day, 7 days a week, or have arrangements for telephone coverage by another UnitedHealthcare Community Plan participating Primary Care Physician or obstetrician. A Medical Director or Physician Reviewer must approve coverage arrangements that vary from this requirement. PCPs and obstetricians are expected to respond to after-hour patient calls within 30-45 minutes for non-emergent symptomatic conditions and within 15 minutes for crisis situations. UnitedHealthcare Community Plan tracks and follows up on all instances of PCP or obstetrician unavailability. UnitedHealthcare Community Plan

also conducts periodic access surveys to monitor for 24/7 after-hours access. PCPs and obstetricians are required to participate in all activities related to these surveys.

12.4 Timeliness Standards for Appointment Scheduling

Providers shall comply with the following appointment availability standards:

Emergency Care

Immediately upon the member's presentation at a service delivery site.

Primary Care

PCPs and providers of primary care should arrange appointments for:

- Appointment Times: Not to exceed six from the date of a patient's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one (1) day.
- Non-urgent, symptomatic (i.e., routine care) office visits shall be available from the enrollee's PCP or another provider within 3 weeks from the date of a patient's request. A non-urgent, symptomatic office visit is associated with the presentation of medical signs not requiring immediate attention.
- Non-symptomatic (i.e., preventive care) office visits shall be available from the enrollee's PCP or another provider within 3 weeks from the date of a patient's request. A non-symptomatic office visit may include, but is not limited to, well/preventive care such as physical examinations, annual gynecological examinations, or child and adult immunizations.
- Transitional health care by a PCP shall be available for clinical assessment and care planning within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders or discharge from a substance use disorder treatment program. Transitional health care by a home care nurse or home care registered counselor shall be available within seven calendar days of discharge from inpatient or institutional care for physical or behavioral health disorders, or discharge from a substance use disorder treatment program, if ordered by the enrollee's PCP or as part of the discharge plan.

Specialty Care

Specialists and specialty clinics should arrange appointments for:

- Urgent care within one day request
- Non-urgent "sick" visit within 48–72 hours of request, as clinically indicated
- Non-urgent care within 30 days of request

Behavioral Health (Mental Health and Substance Use Disorders)

Behavioral health providers should arrange appointments for:

Mental Health

- Post-stabilization services within 1 hour
- Emergent appointments within three hours
- Urgent within 24 hours
- Planned IP psychiatric within five working days
- Routine outpatient services within nine working days

Substance Use Disorders

- Emergent appointments immediately
- Urgent within 24 hours
- Routine within 14 days
- IV drug users who have used within the last six months within 14 days

Prenatal Care

Providers of prenatal care should arrange appointments for the initial prenatal visit:

- First trimester – within three weeks of the member's request
- Second trimester – within two weeks of the member's request
- Third trimester – within one week of the member's request

12.5 Timeliness Standards for Notifying Members of Test Results

Providers should notify members of laboratory or radiology test results within 24 hours of receipt of results in urgent or emergent cases. Providers should notify members of non-urgent, non-emergent laboratory and radiology test results within 10 business days of receipt of results.

12.6 Allowable Office Waiting Times

Members with appointments should not routinely be made to wait longer than 45 minutes.

12.7 Provider Office Standards

UnitedHealthcare Community Plan requires a clean and structurally sound office that meets applicable Occupational Safety and Health Administration (OSHA) and Americans with Disabilities (ADA) standards. Financial incentives for completing physical improvements to meet ADA accessibility standards are available to providers that qualify as small businesses (up to 30 FTE employees or less than $1 million gross revenue). Tax credits are available for "access expenditures" ranging from $250 to $10,250 and tax deductions are available up to $15,000 per year for expenses associated with the removal of barriers.

12.8 Medical Record Charting Standards

All participating primary care UnitedHealthcare Community and State practitioners are required to maintain medical records in a complete and orderly fashion which promotes efficient and quality patient care. Participating practitioners are subject to UnitedHealthcare Community and State's periodic quality review of medical records to determine compliance to the following medical record keeping requirements.

Confidentiality of Records

Office policies and procedures exist for the following:

- Confidentiality of the patient medical record
- Initial and periodic training of office staff concerning medical record confidentiality
- Release of information
- Record retention
- Availability of medical record when housed in a different office location (as applicable)

Record Organization

- An office policy exists that addresses a process to respond to and provide medical records upon request of patients to include a provision to provide copies within 48 hours in urgent situations
- Medical records are maintained in a current, detailed, organized and comprehensive manner. Organization should include evidence of:
  - Identifiable order to the chart assembly
  - Papers are fastened in the chart
  - Each patient has a separate medical record
- Medical records are:
  - Filed in a manner for easy retrieval
  - Readily available to the treating practitioner where the member generally receives care
  - Promptly sent to specialty providers upon patient request and within 48 hours in urgent situations.

Medical records are:

- Stored in a manner that ensures protection of confidentiality
- Released only to entities as designated consistent with federal requirements.
- Kept in a secure area accessible only to authorized personnel

Procedural Elements	**Medical records are legible*** • All entries are signed and dated • Patient name/identification number is located on each page of the record. • Linguistic or cultural needs are documented as appropriate • Medical records contain demographic data that includes name, identification numbers, date of birth, gender, address, phone number(s), employer, contact information, marital status and an indication whether the patient's first language is something other than English • Mechanism for monitoring and handling missed appointments is evident • An executed advance directive is in a prominent part of the current medical record for adults 18 years and older, emancipated minors and minors with children. Adults 18 years and older, emancipated minors and minors with children are given information regarding advance directives. • **A problem list includes a list of all significant illnesses and active medical conditions** • **A medication list includes prescribed and over the counter medications and is reviewed annually*** • **Documentation of the presence or absence of allergies or adverse reactions is clearly documented ***

History	An initial history (for patients seen three or more times) and physical is present to include: • **Medical and surgical history *** • A family history that minimally includes pertinent medical history of parents and/or siblings • A social history that minimally includes pertinent information such as occupation, living situations, education, smoking, ETOH, and/or substance abuse use/history beginning at age 11 • Current and history of immunizations of children, adolescents and adults Screenings of/for: • Recommended preventive health screenings/tests • Depression • High risk behaviors such as drug, alcohol and tobacco use; and if present, advise to quit • Medicare patients for functional status assessment and pain • Adolescents on depression, substance abuse, tobacco use, sexual activity, exercise and nutrition and counseling as appropriate

Problem Evaluation and Management	• Documentation for each visit includes:
	  • Appropriate vital signs (Measurement of height, weight, and BMI annually)
	  • Chief complaint *
	  • Physical assessment *
	  • Diagnosis*
	  • Treatment plan*
	• Tracking and referral of age and gender appropriate preventive health services consistent with Preventive Health Guidelines
	• Documentation of all elements of age appropriate federal Early, Periodic, Screening, Diagnosis and Treatment (EPSDT)
	• Clinical decisions and safety support tools are in place to ensure evidence based care, such as flow sheets
	• Treatment plans are consistent with evidence-based care and with findings/diagnosis
	  • Timeframe for follow-up visit as appropriate
	  • Appropriate use of referrals/consults, studies, tests
	• X-rays, labs consultation reports are included in the medical record with evidence of practitioner review
	• There is evidence of practitioner follow-up of abnormal results
	• Unresolved issues from a previous visit are followed up on the subsequent visit
	• There is evidence of coordination with behavioral health provider
	• Education, including lifestyle counseling is documented
	• Patient input and/or understanding of treatment plan and options is documented
	• Copies of hospital discharge summaries, home health care reports, emergency room care, physical or other therapies, as ordered by the practitioner are documented.

Screening and Documentation Tools

Most of these tools were developed by UnitedHealthcare Community Plan with assistance from the Provider Advisory Subcommittee to help you comply with regulatory requirements and practice in accordance with accepted standards.

12.9 Medical Record Review

On a routine basis, UnitedHealthcare Community Plan will conduct a review of the medical records you maintain for our members. Physicians are expected to achieve a passing score of 85 percent or better. Medical Records should include:

- Initial health assessment, including a baseline comprehensive medical history, which should be completed in less than two (2) visits and documented, and ongoing physical assessments documented on each subsequent visit.
- Problem list, includes the following documented data:
  - Biographical data, including family history
  - Past and present medical and surgical intervention
  - Significant illnesses and medical conditions with dates of onset and resolution
  - Documentation of education/counseling regarding HIV pre and post test, including results
- Entries dated and the author identified
- Legible entries
- Medication allergies and adverse reactions are prominently noted. Also note if there are no known allergies or adverse reactions.
- Past medical history is easily identified and includes serious illnesses, injuries and operations (for patients seen three or more times). For children and adolescents (18 years or younger), past history relates to prenatal care, birth, operations and childhood illnesses.
- Medication record includes name of medication, dosage, amount dispensed and dispensing instructions.
- Immunization record
- Document tobacco habits, alcohol use and substance abuse (12 years and older).
- Copy of Advance Directive, or other document as allowed by state law, or a notation that patient does not want one.
- History of physical examination (including subjective and objective findings)
- Unresolved problems from previous visit(s) addressed in subsequent visits Diagnosis and treatment plans consistent with findings
- Lab and other studies as appropriate
- Patient education, counseling and/or coordination of care with other physicians or health care professionals
- Notation regarding the date of return visit or other needed follow-up care for each encounter
- Consultations, lab, imaging and special studies initialed by primary physician to indicate review
- Consultation and abnormal studies including follow-up plans

Patient hospitalization records should include, as appropriate:

- History and physical
- Consultation notes
- Operative notes
- Discharge summary
- Other appropriate clinical information
- Documentation of appropriate preventive screening and services
- Documentation of behavioral health assessment (CAGE-AID, TWEAK AND PHQ-9)

12.10 Protect Confidentiality of Member Data

UnitedHealthcare Community Plan members have a right to privacy and confidentiality of all records and information about their health care. We disclose confidential information only to business associates and affiliates who need that information to fulfill our obligations and to facilitate improvements to our members' health care experience. We require our associates and business associates to protect privacy and abide by privacy law. If a member requests specific medical record information, we will refer the member to you as the holder of the medical records. Provider will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of member medical information. Provider agrees specifically to comply in all relevant respects with the applicable requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and associated regulations, in addition to the applicable state laws and regulations. UnitedHealthcare Community Plan uses member information for treatment, operations and payment. UnitedHealthcare Community Plan has safeguards to prevent unintentional disclosure of protected health information (PHI). This includes policies and procedures governing administrative and technical safeguards of protected health information. Training is provided to all personnel on an annual basis and to all new employees within the first 30 days of employment.

Chapter 13: Provider Communications

The UnitedHealthcare provider education and training program is built on 27 years of experience with providers and multi-state managed care programs and includes the following training components:

- Provider website
- Provider forums/town hall meetings
- Provider office visits
- Provider bulletins
- Provider manual

13.1 Provider Website

UnitedHealthcare promotes the use of web-based functionality among its provider population. UnitedHealthcare's web-based provider website, **UHCCommunityPlan.com**, facilitates provider communications pertaining to administrative functions. Our interactive website enables providers to electronically determine member eligibility, submit claims, and ascertain the status of claims. UnitedHealthcare has implemented an internet-based prior authorization system on UHCCommunityPlan.com which allows providers who have internet access the ability to request their medical prior authorizations online rather than by telephone. The UnitedHealthcare Community Plan also contains an online version of the Provider Administrative Guide, the Provider Directory, access to the Iowa Preferred Drug List (both searchable and comprehensive listing), clinical practice guidelines, quality and utilization requirements and educational materials such as newsletters, recent fax service bulletins and other provider information. UnitedHealthcare also posts notifications regarding changes in laws, regulations and subcontract requirements to the portal such as the Issues Log, which is located at http://www.uhccommunityplan.com/health-professionals/ia.html.

A website is also available to members including access to the Member Handbook, newsletters, provider search tool and other important Health Plan bulletins.

13.2 Provider Office Visits

Physician Advocates visit primary care providers (PCP), specialist and ancillary provider offices on a regular basis. Each Physician Advocate is assigned to a geographic territory to deliver face-to-face support to our providers across the state. The prioritization and quantity of provider office visits by these staff is determined based on a variety of demographic factors, including size of member population, special cultural/linguistic needs, geography, and other special needs. Our primary reasons for face-to-face office visits are to create program awareness, promote program compliance, and minimize health care disparities.

13.3 Provider Bulletins

We will also communicate policy updates to you through news Bulletins located at UHCCommunityPlan.com > For Health Care Professionals > Select your State > Iowa > Bulletins.

13.4 Provider Administrative Guide/Manual

UnitedHealthcare publishes this Guide online, which includes an overview of the program, toll free number to our provider services hotline, a removable quick reference guide, and a list of additional provider resources and incentives. Providers without Internet access may request a hard copy of this Guide by contacting Provider Services.

Chapter 14: Covered Benefits

Health benefits are governed by our contract with the Iowa Department of Human Services and include; medical, vision, behavioral health including HCBS and Habilitation, and pharmacy services. All covered services are available regardless of pre-existing conditions, prior diagnoses, or receipt of any prior health care services. UnitedHealthcare shall impose copayments for Iowa Health and Wellness Plan participants in accordance with the State's 1115 waiver and hawk-i members in accordance with the State's CHIP State Plan. For all other enrolled populations, the Contractor may elect, but is not required, to impose copayments as outlined in the State Plan.

We provide a benefit package which includes Fee-for-Service (FFS) services covered under the Iowa Medicaid program. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care, our (policies), reimbursement policies and clinical practice guidelines. Please refer to the current Iowa Medicaid Provider Manual located at www.dhs.iowa.gov for listing of limitations and exclusions.

Value Added Services
We offer additional services at no cost to the member. These special services are selected to address member needs and experiences in an effort to help them live healthier lives. Members are informed of these services through their UnitedHealthcare Community Plan of Iowa welcome packet. Value-added services are highlighted in the member newsletter, listed in the member handbook and at UHCCommunityPlan.com. Information about services that are diagnosis-specific, such as diabetes and pregnancy, are mailed to the member's home.

Members are able to directly access most of these services. Some services require assistance from your office. All are limited to in-network providers. For the most current Value-added Services, please visit UHCCommunityPlan.com > For Healthcare Professionals > Iowa> Billing & Reference Guides > Value Added Services. You may also call Provider Services at 888-650-3462.

Benefits
Health benefits are governed by UnitedHealthcare Community Plan's contract with the Iowa Department of Human Services and include; medical, vision, behavioral health including HCBS and Habilitation and pharmacy services. All covered services are available regardless of pre- existing conditions, prior diagnoses, or receipt of any prior health care services. UnitedHealthcare Community Plan provides a benefit package which includes Fee-for-Service (FFS) services currently covered under the Iowa Medicaid program. Services for members are limited to those that are medically necessary and appropriate, and which conform to professionally accepted standards of care. Please refer to the current Iowa Medicaid Provider Manual located at dhs.iowa.gov for listing of limitations and exclusions. The Iowa Medicaid manual includes minimum service requirements.

The following benefit information is a summary. Some procedures, including certain medical services or benefits provided, require prior authorization by UnitedHealthcare before rendering services. Call Provider Services to check eligibility coverage for Iowa Medicaid members.

Covered Benefits

Service	
Children's Care	
Newborn Care	Newborn screenings are covered. Circumcisions performed on male newborns before leaving the hospital are covered.
Immunizations & Vaccines (shots)	You can get these at the doctor's office or the local health department. Immunizations and vaccines are covered according to the Centers for Disease Control and Prevention (CDC) and American Academy of Pediatrics vaccination schedule.
Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services (under 21 years old)	Covered services include: • Well-child visits • Developmental screening • Vision testing • Behavioral screening • Immunizations • Hearing testing
Lead Screening	Lead screenings can be done at the doctor's office or local health department.
Office Visits	Well-child visits, routine visits and sick visits are covered.
Women's Care	
Family Planning	Family planning offers counseling, supplies, routine care and treatment for sexually transmitted infections (STIs). This care is private. You can go to any provider that offers these services. Also includes family planning drugs, supplies and devices. These include, but are not limited to, generic birth control pills, shots, IUDs and diaphragms.
Obstetric & Maternity Care	You are covered for • Doctor and hospital care before your baby is born (prenatal care) • Delivery • Care after birth (postpartum care) • Certified midwife care • Birthing and parenting classes You may go to your OB/GYN for care without a referral. You can stay in the hospital up to 2 days after a normal vaginal delivery and up to 4 days after a Cesarean delivery.
Well-Care for Women	You may see an OB or OB/GYN for routine office visits, mammograms, Pap tests and family planning. No referral is needed.
Sterilization	Sterilization requires prior authorization. The Iowa Department of Human Services requires Consent form. The provider must submit the consent form with the claim.
Abortions	Abortion services are limited to coverage based on federal and state laws and regulations. No services associated with an abortion will be

	covered unless criteria are met. The appropriate Certification of Medical Necessity for Abortion form must be complete and submitted, along with supporting document and the claim.
Emergency and Urgent Hospital Care	
Ambulance Services	Emergent and non-emergent transportation by an ambulance is covered.
Emergency Room Care	Emergency care is for a medical issue that is a threat to your life or that can badly harm your health if you do not get care right away. Here are some examples of emergencies: • Convulsions • Chest paid • High fever • Serious breathing problems • Broken bones • Loss of consciousness (fainting or blackout) Emergency care does not need prior authorization and you can get care anywhere in the USA. This includes post-stabilization care. Post-stabilization care includes the care you get after an emergency to make you stable or to maintain, improve or resolve your health condition.
Medical Inpatient Care	Hospital inpatient care is covered when medically necessary. Includes medical, surgical, post-stabilization, acute and rehabilitative services. The hospital must notify UnitedHealthcare.
Urgent Care Visits	Urgent care is for problems that need prompt medical attention, but are not life threatening. Here are some examples of urgent care. • Sore throat or cough • Back pain • Earache • Flu or cold symptoms • Minor injury Visits to an urgent care center are covered.
Outpatient Care	
Doctor Visits	Routine and preventive care services including doctor visits, preventive services, clinic visits and outpatient doctor care are covered.
Cardiac & Pulmonary Rehab	Covered when medically necessary.
Home Health Services	Services in the home include visits by aides, private duty nursing, physical/occupational/speech therapy, skilled nursing, social workers and home infusion. Prior authorization is required and limitations may apply.
Rehabilitative Therapy	This type of care is given after serious illness or injury to restore function. Covered therapy includes physical, occupational and speech. These are covered when medically necessary. Limit of xx combined visits per calendar year per disability.
Specialty Care (Office Visits & Clinics)	Care with a specialist is covered. Talk to your doctor to see if you

	need specialty care. You do not need a referral to go to a network specialist.
Diagnostic Testing	Diagnostic lab tests are covered.
Surgery	
Outpatient Surgery	Medically necessary outpatient surgeries may be performed in a hospital or in an ambulatory surgery center. Some surgeries require prior authorization. Talk with your PCP.
Hospice	
Hospice Care	Hospice care is for people with an illness causing limited life expectancy as decided by your doctor. It is most often given in the home. Your doctor will help you arrange the care. Hospice care requires prior authorization.
Other Covered Care & Programs	
Asthma Care	Covered equipment, supplies and services include: • Peak flow meters • Spacers • Nebulizers & masks • Regular doctor visits • Specialist visits • Other supplies needed to manage asthma
Chiropractic Services	Chiropractic manipulative therapy eligible for reimbursement is specifically limited to the manual manipulation of the spine for the purpose of correcting a subluxation demonstrated by x-ray. Subluxation means an incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing of the vertebrae. X-rays are limited to one per condition. Additional x-rays are not covered. Routine adjustments are not covered. Services which do not seek to cure, or which are provided during periods when the medical condition of the patient who requires the service is not changing are not covered. Prior authorization is required.
Diabetic Supplies	All diabetic supplies including, but not limited to, alcohol swabs, syringes, test strips and lancets. Diabetic supplies can be from a network pharmacy.
Durable Medical Equipment (DME) and Supplies	Equipment and supplies for medical purpose. May include, but are not limited to: oxygen tanks, ventilators, wheelchairs, crutches, orthotic devices, prosthetic devices, pacemakers, and medical supplies. Some items require prior authorization.
Vision Services	Vision exams, prescription lenses, eyeglasses, cataract removal, and

	prosthetic eyes, if prescribed. One complete eye exam and one pair of glasses are covered for members 21 years of age and older, every year. Repairs shall be provided as needed. Eyeglasses, repairs and exams as needed for members under 21 years old. Eye exams, as needed, for post-cataract surgery up to one year following the surgery and eyeglasses for post-cataract surgery when provided within one ear following surgery. Contact lenses and replacements are covered with prior approval, when ordered by a qualified health plan provider and when such lenses provide better management of some visual or ocular conditions than can be achieved with eyeglass lenses. Artificial eyes are covered.
Hearing Services	Includes diagnostic screening, preventive visits and hearing aids. One routine visit every 12 months. Hearing aids, both analog and digital, are covered. Lost, broken or destroyed hearing aids will be replaced one time during a four-year time period with a prior authorization. Binaural hearing aids are covered. [One hearing aid per ear every 4 years.] Requires specific medical necessity documents. Hearing aid repairs are covered. [Hearing aid batteries are covered, but limited to xx per month for monaural and xx per month for binaural.]
Nutritional Classes/Counseling	Nutritional services/counseling must be given by a licensed dietician. It is covered for certain medical conditions, like diabetes.
Podiatry (Foot) Care	Covered when medically necessary for conditions, like diabetes. Routine foot care is not covered.
Mental Health and Substance Abuse Services	Mental health and substance abuse services are covered. This includes: *Inpatient and outpatient services * Individual and group therapy with physicians, psychologists, social workers, counselors, or psychiatric nurses. *Prescription drugs for therapeutic purposes *Partial hospitalization and day treatment services Some services have limitations and require prior authorization.
Prescription and Over-the-Counter (OTC) Drugs	Prescriptions are covered according to the State's Preferred Drug List (PDL).

Non-Emergency Transportation	Transportation to and from medical appointments are covered if you qualify and have no other way to get there. Must be medically necessary appointments or to go to the pharmacy. Prior authorization may be required.

HCBS Benefits

In addition to the Medicaid benefits you provide, as an HCBS Waiver provider, you also will provide some of the following services. The following benefit chart shows what waivers cover each service.

Prior Authorization is required for all of the following services. Some limitations may apply.

Service	Description	Home and Community-Based Services (HCBS) Waivers
Adult Day Care	Program of support care in a group environment with supervision and assistance on a regular or intermittent basis in a day care center.	• AIDS/HIV • Brain Injury • Elderly • Health & Disability • Intellectual Disability
Assistive Devices	Equipment to assist members with activities of daily living to allow the member more independence. Devices include, but are not limited to: • Long-reach brush • Extra-long shoe horn • Non-slip grippers to pick up and reach items • Dressing aids • Transfer boards • Shampoo rinse tray and inflatable shampoo tray • Double-handled cup and sipper lid	• Elderly
Behavioral Programming	Individually designed programs to increase the member's appropriate behaviors and decrease the member's maladaptive behaviors that have interfered with the member's ability to remain in the community.	• Brain Injury
Case Management Services	For the brain injury waiver, services provided to: • Ensure the member received an evaluation and diagnosis, • Assist member in getting needed services and living arrangements, • Coordinate the delivery of services, and • Monitor to ensure services continue and the selected living arrangement is appropriate. For the elderly waiver, services assist members who reside in a community setting or are transitioning to a community setting. To gain access to needed medical, social,	• Brain Injury • Elderly

	educational, housing, transportation, vocational, and other appropriate services in order to ensure the health, safety, and welfare of the member.	
Chore	Assist with the household maintenance activities as necessary to allow a member to remain in their own home safely and independently.	• Elderly
Consumer-directed Attendant Care (CDAC)	Activities performed by a person to help a member with self-care tasks that the member would typically do independently if the member were otherwise able. CDAC services must be cost-effective and necessary to prevent institutionalization.	• AIDS/HIV • Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability
Counseling	Face-to-face non-psychiatric mental health services necessary to: • Manage depression, • Assistance with the grief process, • Alleviation of psychosocial isolation, and • Support to cope with a disability or illness, including terminal illness.	• AIDS/HIV • Health & Disability
Day Habilitation	Regularly scheduled activities in a non-residential setting, separate from the member's private residence or other residential living arrangement, such as: • Assist with acquisition, retention, or improvement in self-help; • Socialization and adaptive skills that enhance social development; and • Develop skills in performing activities of daily living and community living.	• Intellectual Disability
Personal Emergency Response System	A call button so the member can get help in an emergency. Use it when the caregiver is not around. This service is not available if the member: - Lives in a nursing home, or - The facility already has a way to help the member when needed.	• Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability
Environmental Modifications and Adaptive Devices	Items installed or used within the member's home that address specific, documented health, mental health, or safety concerns.	• Children's Mental Health
Family and Community Support	Support the member and the member's family by the development and implementation of strategies and interventions that will result in the reduction of stress and depression and will increase the member's and the family's social and emotional strength.	• Children's Mental Health
Family Counseling and Training	Services are face-to-face mental health services provided to the member and the family with whom the member lives (or who routinely provides care to the member) to increase the member's or family members' capabilities to maintain and care for the member in the community.	• Brain Injury
Home Delivered	Each meal shall ensure the member receives a minimum of	• AIDS/HIV

Meals	one-third of the daily-recommended dietary allowance, as established by the Food and Nutrition Board of the National Research Council of the National Academy of Sciences. The meal may also be a liquid supplement that meets the minimum one-third standard. A maximum of 2 meals per day or 14 meals per week is allowed.	• Elderly • Health & Disability
Home Health Aide	Unskilled medical services that provide direct personal care.	• AIDS/HIV • Elderly • Health & Disability • Intellectual Disability
Homemaker	Provided when the member lives alone or when the person who usually performs these functions for the member needs assistance with performing the functions.	• AIDS/HIV • Elderly • Health & Disability
Home/Vehicle Modifications	Physical modifications to the member's home or vehicle that directly address the member's medical or remedial need. Covered modifications must be necessary to provide for the health, welfare, or safety of the member and enable the member to function with greater independence in the home or vehicle.	• Brain Injury • Elderly • Health & Disability • Intellectual Disability • Physical Disability
In-home Family Therapy	Skilled therapeutic services to the member and family that will increase their ability to cope with the effects of serious emotional disturbance on the family unit and the familial relationships. The service must support the family by the development of coping strategies that will enable the member to continue living within the family environment.	• Children's Mental Health
Interim Medical Monitoring & Treatment (IMMT)	Services are monitoring and treatment of a medical nature requiring specially trained caregivers.	• Brain Injury • Health & Disability • Intellectual Disability
Mental Health Outreach	Services provided in a member's home to identify, evaluate, and provide treatment and psychosocial support. The services can be provided only on the basis of a referral from the member's interdisciplinary team.	• Elderly
Nursing	Services provided to a member by licensed agency nurses in the home. Must be included in the plan of treatment established by the physician. The services must be reasonable and necessary to the treatment of an illness or injury. Services should be based on medical necessity of the member.	• AIDS/HIV • Elderly • Health & Disability • Intellectual Disability
Nutritional Counseling	Services provided for a nutritional problem or condition of such severity that nutritional counseling beyond that normally expected as part of the standard medical management is needed.	• Elderly • Health & Disability
Prevocational Services	Services that provide learning and work experiences, including volunteer work, where the member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services are expected to occur over a defined period of time and with specific outcomes to be achieved, as determined by the member	• Brain Injury • Intellectual Disability

	and the member's service and supports planning team through an ongoing person-centered planning process.	
Respite: Basic Individual	Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation. Individual respite is provided on a ratio of one staff-to-one member. The member does not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.	• AIDS/HIV • Brain Injury • Children's Mental Health • Elderly • Health & Disability • Intellectual Disability
Respite: Group	Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation. Group respite provided on a ratio of one staff-to-two or more members receiving respite. These members do not have specialized medical needs that require the direct services of a registered nurse or licensed practical nurse.	• AIDS/HIV • Brain Injury • Children's Mental Health • Elderly • Health & Disability • Intellectual Disability
Respite: Specialized	Services provided to the member that give temporary relief to the usual caregivers and give all the necessary care that the usual caregiver would during that time. The purpose of respite care is to enable members to remain in their current living situation. Respite provided on a staff-to-member ratio of one-to-one or higher to members with specialized medical needs requiring the care, monitoring or supervision of a licensed registered nurse or licensed practical nurse.	• AIDS/HIV • Brain Injury • Children's Mental Health • Elderly • Health & Disability • Intellectual Disability
Senior Companion	Include nonmedical care supervision, oversight, and respite services. Companions may assist with meal preparation, laundry, shopping, and light housekeeping tasks. This service cannot provide hands-on nursing or medical care.	• Elderly
Specialized Medical Equipment	Medically necessary items for personal use by a member for the member's health and safety, such as: • Electronic aids and organizers • Medicine dispensing devices • Communication devices • Bath aids • Environmental control units • Repair and maintenance of items purchased through the waiver	• Brain Injury • Physical Disability
Supported Community Living (SCL)	Services provided within the member's home and community, according to the individualized member's needs as identified in the approved service plan.	• Brain Injury • Intellectual Disability
Supported Community Living:	Medical or remedial services provided to children under the age of 18 while living outside their family home. The residential-based living environment is furnished by the	• Intellectual Disability

Residential-Based (RBSCL)	residential-based supported community living service provider. The services remove barriers to family reunification or develop self-help skills for maximum independence.	
Supported Employment (SE)	Individual employment support services for members who, due to disabilities, need ongoing support to obtain and maintain an individual job.	• Brain Injury • Intellectual Disability
Transportation	Transportation services may be provided for members: • To conduct business errands and essential shopping, • To receive medical services not reimbursed through medical transportation, • To travel to and from work or day programs (BI, ID, and PD), or • To reduce social isolation.	• Brain Injury • Elderly • Intellectual Disability • Physical Disability

Behavioral Health Benefits

Mental Health Services

- Outpatient therapy provided by a licensed qualified provider including family therapy and in-home family therapy as medically necessary to address the needs of the child or other members in the family;
- Medication management provided by a professional licensed to prescribe medication;
- In-patient hospital psychiatric services including, except as limited, services in the state mental health institutes;
- Services that meet the concurrent substance use disorder and mental health needs of individuals with co-occurring condition;
- Community-based and facility based sub-acute services;
- Crisis Services including, but not limited to:
    - 24 hour crisis response;
    - Mobile crisis services;
    - Crisis assessment and evaluation;
    - Non-hospital facility based crisis services;
    - Twenty-three (23) hour observation in a twenty-four (24) hour treatment facility;
- Care consultation by a psychiatric physician to a non-psychiatric physician;
- Integrated health home mental health services and supports;
- Intensive psychiatric rehabilitation services;
- Peer support services for persons with serious mental illness;
- Community support services including, but not limited to:
    - Monitoring of mental health symptoms and functioning/reality orientation,
    - Transporting to and from behavioral health services and placements,
    - Establishing and building supportive relationship,
    - Communicating with other providers,
    - Ensuring member attends appointments and obtains medications, crisis intervention and developing a crisis plan, and
    - Developing and coordinating natural support systems for mental health support;
- Habilitation program services;

- Children's mental health waiver services;
- Stabilization services;
- In-home behavioral management services;
- Behavioral interventions with child and with family including behavioral health intervention services (BHIS) and both Medicaid and non-Medicaid funded applied behavior analysis (ABA) services for children with autism; and
- Psychiatric Medical Institutions for Children (PMIC)

Substance Use Disorder Services

i. Outpatient treatment;
ii. Ambulatory detoxification;
iii. Intensive outpatient;
iv. Partial hospitalization (day treatment);
v. Clinically managed low intensity residential treatment;
vi. Clinically managed residential detoxification;
vii. Clinically managed medium intensity residential treatment;
viii. Clinically managed high intensity residential treatment;
ix. Medically monitored intensive inpatient treatment;
x. Medically monitored inpatient detoxification;
xi. Medically managed intensive inpatient services;
xii. Detoxification services including such services by a provider licensed under chapter 135B;
xiii. Peer support and peer counseling;
xiv. PMIC substance use disorder services consisting of treatment provided by a substance use disorder licensed PMIC and consistent with the nature of care provided by a PMIC as described in Iowa Code chapter 135H;
xv. Emergency services for substance use disorder conditions;
xvi. Ambulance services for substance use disorder conditions;
xvii. Intake, assessment and diagnosis services, including appropriate physical examinations, urine screening and all necessary medical testing to determine a substance use disorder diagnosis, identification of medical or health problems, and screening for contagious diseases;
xviii. Evaluation, treatment planning and service coordination;
xix. Substance use disorder counseling services when provided by approved opioid treatment programs that are licensed under Iowa Code Chapter 125;
xx. Substance use disorder treatment services determined necessary subsequent to an EPSDT screening;
xxi. Substance use disorder screening, evaluation and treatment for members convicted of Operating a Motor Vehicle While Intoxicated (OWI), Iowa Code Section 321J.2 and members whose driving licenses or non-resident operating privileges are revoked under Chapter 321J, provided that such treatment service meets the criteria for service necessity;
xxii. Court-ordered evaluation for substance use disorder;
xxiii. Court-ordered testing for alcohol and drugs;
xxiv. Court-ordered treatment which meets criteria for treatment services; and
xxv. Second opinion as medically necessary and appropriate for the member's condition and identified needs from a qualified health care professional within the network or arranged for outside the network at no cost to the member.

14.2 Verifying Eligibility and Prior Authorizations

It is your responsibility to verify member eligibility and to secure any necessary authorizations prior to delivering a service to ensure payment.

Link is our single point of online entry to see whether a patient of yours is a current member of our health plan and to see if a service requires a prior authorization. A pop-up will prompt you to make the request for any service that requires prior authorization. Visit Cloud.Oputm.com > secure login > Eligibility & Benefits Application.

Please know that payment may be denied for services you provided which we determined to be medically unnecessary. You may not bill our members for such services unless the member has, with knowledge of our determination of a lack of medical necessity, understands and agrees in writing to be responsible for payment of those charges prior to the delivery of those services.

You may also verify member eligibility and request a prior authorization over the phone by calling **888-650-3462.**

Prior authorization requests for medical necessity review may also be faxed to **888-899-1680.**

Fax forms are located at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Forms > Prior Authorization Faxed Request Form or Prescription Drug Prior Authorization Request Form. Or see the Pharmacy Program tab for some drug-specific forms. Note that drug prior authorization requests should be faxed to **866-940-7328**. Please see the Pharmacy section of this manual for additional drug authorization information.

Notes: Radiology and Cardiology have a unique prior authorization process posted to UHCCommunityPlan.com > For Health Care Professionals > Iowa > Radiology or Cardiology xx link.

Long term services and support services for Home and Community-Based Waiver program authorizations are secured by the case manager-based on assessment of need and within the member care plan.

A complete list of services that require authorizations is posted to UHCCommunityPlan.com > For Health Care Professionals > Iowa > Billing and Reference Guides.

Please note that UnitedHealthcare Community Plan does not reward for denials or provide financial incentives that encourage under-utilization. The criteria are available in writing upon request or by calling **888-650-3462**.

The services provided, as well as the type of provider and setting, must reflect the level of services that can be safely provided, must be consistent with the diagnosis of the condition and appropriate to the specific medical needs of the member and not solely for the convenience of the member or provider of service. In addition, the services must be in accordance with standards of good medical practice and generally recognized by the medical scientific community as effective.

Prior authorization Resources

- Milliman Care Guidelines (MCG) are followed for medical necessity criteria located at www.careguidelines.com
- See our Clinical Practice Guidelines located at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Clinical Practice Guidelines

- The Iowa Medicaid Provider Procedures Manual at DHS.Iowa.Gov > Policy Manual > Medicaid Provider
- Covered CPT codes are located at UnitedHealthcareonline.com > Tools & Resources > Policies, Protocols and Guides > UnitedHealthcare Community Plan Medical Policies and Coverage Determination Guidelines
- Reimbursement Policy considerations are located at UHCCommunityPlan.com > For Healthcare Professionals > Iowa > Reimbursement Policies

Rehabilitation Therapy Prior Authorization Components
Physical, Therapy, Occupational Therapy and Speech Therapy request for prior authorization for services should include the following components:

A copy of the physician's order for physical therapy, occupational therapy and speech/language pathology services must be retained with the medical record.

To verify services provided in the course of a post payment review, documentation in the beneficiary's medical record must support the service billed. Documentation must be legible and complete. Proper documentation does not need to be in any specific format. However, it must include the following:

- Pertinent past and present medical history with approximate date of diagnosis
- Identification of expected goals or outcomes
- Description of therapy and length of time spent on treatment
- Beneficiary's response to therapy
- Progress toward goal(s)
- Date and signature of therapist by each entry

14.3 Pharmacy Services

Our Preferred Drug List (PDL) is comprised of drugs recommended to the Iowa Department of Human Services by the Iowa Medicaid Pharmaceutical and Therapeutics Committee that have been identified as being therapeutically equivalent within a drug class and that provide cost benefit to the Medicaid program. Any changes to the PDL or the prior authorization process will be communicated to you with a minimum of 30 days advanced notice via a bulletin posting to the UHCCommunityPlan.com > For Health Care Providers > Iowa > Pharmacy Program.
The Iowa Department of Human Services developed a Recommended Drug List (RDL) as recommended by the Iowa Medicaid Pharmaceutical and Therapeutics Committee. This voluntary list of drugs represents the most cost-effective drugs in those categories.

The formulary of approved drugs is posted with the PDL at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Pharmacy.

Pharmacists receiving a prescription for a drug which requires prior authorization but for which the authorization has not been obtained, should work with the prescribing physician to see if the prescription can be changed to a preferred alternative medication. If a preferred alternative is not appropriate, the physician should then be instructed to contact the Pharmacy Provider Services at 888-650-3462 with questions concerning the prior authorization process.

Day Supply Dispensing Limitations

Members may receive up to a one-month supply (31 days) of medication per prescription order or prescription refill. A medication may be reordered or refilled when 90 percent of the medication has been utilized. If a claim is submitted before 75 percent of the medication has been used, based on the original day supply submitted on the claim, the claim will reject with a "refill too soon" message. Please call the Provider Services at 888-650-3462 with questions or for help with dosage change authorization

Emergency Prescriptions

A 72-hour emergency supply of a prescribed drug must be provided when a medication is needed without delay and prior authorization (PA) is not available. This applies to all drugs requiring a prior authorization (PA), either because they are non-preferred drugs on the Preferred Drug List or because they are subject to clinical edits.

The 72-hour emergency supply should be dispensed any time a PA cannot be resolved within 24 hours for a medication on the Vendor Drug Program formulary that is appropriate for the member's medical condition. If the prescribing provider cannot be reached or is unable to request a PA, the pharmacy should submit an emergency 72-hour prescription.

A pharmacy can dispense a product that is packaged in a dosage form that is fixed and unbreakable, e.g., an albuterol inhaler, as a 72-hour emergency supply.

You will receive a response by telephone or other telecommunication device within twenty-four (24) hours of a request for prior authorization.

Quantity Limitations

UnitedHealthcare places quantity limitations on medications which may differ from limitations placed by the Iowa Vendor Drug Program Fee For Service Program. Types of quantity limitations are described below. Per state regulations, quantity limits do not apply to mental health drugs.

- Prescriptions for monthly quantities greater than the indicated limit require a prior authorization request.
- Quantity limits based on Efficient Medication Dosing (also known as Dose Optimization)
  - The Efficient Medication Dosing Program is designed to consolidate medication dosage to the most efficient daily quantity to increase adherence to therapy and also promote the efficient use of health care dollars.
  - The limits for the Program are established based on FDA approval for dosing and the availability of the total daily dose in the least amount of tablets or capsules daily. Quantity Limits in the prescription claims processing system will limit the dispensing to consolidate dosing.
  - The Pharmacy Claims Processing System will prompt the pharmacist to request a new prescription order from the physician.

Additions to the Quantity Limitations program drug list will be made from time to time and providers notified accordingly. Per state regulations, quantity limits do not apply to mental health drugs. Also, we recognize that a number of patient-specific variables must be taken into consideration when drug therapy is prescribed and therefore overrides will be available through the medical exception (prior authorization) process.

More information regarding drug-specific quantity limits can be found at UHCCommunityPlan.com.

Chapter 15: Glossary

Action – The denial or limited authorization of a requested service, including the type, level or provider of service; reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment of a

service; or failure to provide services or act in a timely manner as required by law or contract.

Acute Inpatient Care – Care provided to persons sufficiently ill or disabled requiring:

1. Constant availability of medical supervision by attending provider or other medical staff

2. Constant availability of licensed nursing personnel

3. Availability of other diagnostic or therapeutic services and equipment available only in a hospital setting to ensure proper medical management by the provider

Ambulatory Care – Health services provided on an outpatient basis. While many inpatients may be ambulatory, the term "ambulatory care" usually implies that the patient has come to a location other than his/her home to receive services and has departed the same day. Examples include chemotherapy and physical therapy.

Ambulatory Surgical Facility – A facility licensed by the state where it is located, equipped and operated mainly to provide for surgeries and obstetrical deliveries, and allows patients to leave the facility the same day surgery or delivery occurs.

Ancillary Services – Health services ordered by a provider, including, but not limited to, laboratory services, radiology services, and physical therapy.

Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan for review of an action.

Authorization – All authorization reviews and communications will be conducted by UnitedHealthcare Community Plan in compliance with all applicable state and federal laws, the State Contract and applicable attachments. UnitedHealthcare Community Plan will establish a process that will allow providers to submit and receive determination via a secure electronic transmission. Used interchangeably with preauthorization or prior authorization.

Average Length of Stay (ALOS) – Measure of hospital utilization calculated by dividing total patient days incurred by the number of admissions/discharges during the period.

Capitation – A prospective payment based on a certain rate per person paid on a monthly basis for a specific range of health care service.

Centers for Medicare & Medicaid Services (CMS) – A federal agency within the U.S. Department of Health and Human Services. CMS administers Medicare, Medicaid, and SCHIP programs.

Children's Health Insurance Plan (CHIP) – A federal/state funded health insurance program authorized by Title XXI of the SSA and administered by the Iowa Department of Health & Environment/Division of Health Care Finance

Claim – A request for payment for the provision of Covered Services prepared on a CMS-1500 form, UB-04, or successor, submitted electronically or by mail.

Clean Claim - A claim submitted in **accordance with 42 C.F.R. 447.45,** as amended from time to time, that can be processed
without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Coordination of Benefits (COB) – Applies when a person is covered under more than one group medical plan. The plans coordinate with each other to avoid duplicate payments for the same medical services.

Complaint – Any written or oral expression of dissatisfaction by a provider.

Contracted Services - Services to be provided by UnitedHealthcare under the terms of our contract

Covered Services – Medically necessary services included in the state contract. Covered services change periodically as mandated by federal or state legislation.

Credentialing – The verification of applicable licenses, certifications, and experience to assure that provider status is extended only to professional, competent providers who continually meet the qualifications, standards, and requirements established by UnitedHealthcare Community Plan.

Current Procedural Terminology (CPT®) Codes – American Medical Association (AMA)-approved standard coding for billing of procedural services performed.

Delivery System – The mechanism by which health care is delivered to a patient. Examples include, but are not limited to, hospitals, providers' office and home health care.

Denied Claims Review – The process for providers to request a review of a denied claim.

Discharge Planning – Process of screening eligible candidates for continuing care following treatment in an acute care facility, and assisting in planning, scheduling and arranging for that care.

Durable Medical Equipment (DME) – Equipment used repeatedly or used primarily and customarily for medical purposes rather than convenience or comfort. It also is equipment that is appropriate for use in the home and prescribed by a provider.

Dual Coverage – When a member is enrolled with two UnitedHealthcare plans at the same time.

Dual Eligible – When a member has Medicare as the other insurance that is primary to Medicaid

Early Periodic Screening Diagnosis and Treatment Program (EPSDT) – A package of services in a preventive (well child) exam covered by Medicaid as defined in SSA section 1905 (R). Services covered by Medicaid include a complete health history and developmental assessment, an unclothed physical exam, immunizations, laboratory tests, health education and anticipatory guidance, and screenings for vision, dental, substance abuse, mental health and hearing, as well as any medically necessary services found during the EPSDT exam.

Electronic Data Interchange (EDI) – The electronic exchange of information between two or more organizations.

Emergency Care – The provision of medically necessary services required for immediate attention to evaluate or stabilize a medical emergency (see definition below).

Expedited Appeal – An oral or written request by a member or member's personal representative received by UnitedHealthcare Community Plan requesting an expedited reconsideration of an action when taking the time for a standard resolution could seriously jeopardize the member's life, health or ability to attain, maintain, or regain maximum function; or would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Expedited Grievance – An expedited grievance is a non-standard time frame request for review of an Adverse Determination; communicated verbally or in writing by a member, a representative of a member or a provider; where the application of the standard time frame would seriously jeopardize a member's life, health, or ability to attain, maintain, or regain maximum function.

Federally Qualified Health Center (FQHC) – A facility that is:

1. Receiving grants under section 329, 330, or 340 of the Public Health Services Act; or
2. Receiving such grants based on the recommendation of Iowa Department of Health and Environment, Division of Health Care Finance (KDHE-DHCF) within the Public Health Service, as determined by the Secretary to meet the requirements for receiving such a grant; or
3. A tribe or tribal organization operating outpatient health programs or facilities under the Indian Self Determination Act (PL93-638).

Fee-For-Service (FFS) – FFS is a term UnitedHealthcare Community Plan uses to describe a method of reimbursement based upon billing for a specific number of units of services rendered to a member.

Grievance – An oral or written expression of dissatisfaction by a member, or representative on behalf of a member, about any matter other than an action received at UnitedHealthcare Community Plan.

Health Plan Employer Data and Information Set (HEDIS) – Set of standardized measures developed by NCQA. Originally HEDIS was designed to address private employers' needs as purchasers of health care. It has since been adapted for use by public purchasers, regulators and consumers. HEDIS is used for quality improvement activities, health management systems, provider profiling efforts, an element of NCQA accreditation, and as a basis of consumer report cards for managed care organizations.

Hearing – An outside hearing conducted by the Office of administrative Hearings available to all

UnitedHealthcare Community Plan members. The member presents their appeal to an Administrative Law Judge. Members may ask for a State Fair Hearing *instead* of a UnitedHealthcare Community Plan appeal or *at the same time* as the UnitedHealthcare Community Plan appeal. Providers must complete the UnitedHealthcare Community Plan appeal process before filing a State Fair Hearing.

HIPAA – Health Insurance Portability and Accountability Act. HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs, and mandates the privacy and security of patient information.

Independent Practice Association (IPA) – A legal entity, the members of which are independent providers who contract with the IPA for the purpose of having the IPA contract with one or more health plans.

Independent Review Organization (IRO) – A review process by a state-contracted independent third party.

Integrated Provider Network Database (IPND) – A database developed to provide verified and integrated provider information for all health plans serving Iowa Department of Health and Environment, Division of Health Care Finance via the Internet and an internal user interface.

Medicaid – The state and federally funded medical program created under Title XIX of the SSA.

Medical Emergency – A medical condition manifesting itself by acute symptoms of sufficient verity (including severe pain) that a prudent layperson, which possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

Medical Records – A confidential document containing written documentation related to the provision of physical, social and mental health services to a member.

(1) A health intervention that is otherwise a Covered Service, is not specifically excluded from coverage, and is medically necessary, according to all of the following criteria:

(A) **"Authority."** The health intervention is recommended by the treating physician and is determined to be necessary. (B**) "Purpose."** The health intervention has the purpose of treating a medical condition.

(C) **"Scope."** The health intervention provides the most appropriate supply or level of service, considering potential benefits and harms to the patient.

(D) **"Evidence."** The health intervention is known to be effective in improving health outcomes. For new interventions, effectiveness shall be determined by scientific evidence as provided in paragraph three. For existing interventions, effectiveness shall be determined as provided in paragraph four.

(E) **"Value."** The health intervention is cost-effective for this condition compared to alternative interventions, including no intervention. "Cost-effective" shall not necessarily be construed to mean the lowest price. An intervention may be medically indicated and yet not be a covered benefit or meet this definition of medical necessity. Interventions that do not meet this definition of medical necessity may be covered at the choice of United. An intervention shall be considered cost effective if the

benefits and harms relative to costs represent an economically efficient use of r esources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative.

(2) The following definitions shall apply to these terms only as they are used in this subsection;

(A) **"Effective"** means that the intervention can be reasonably expected to produce the intended results and to have expected benefits that outw eigh potential harmful effects.

(B) **"Health intervention"** means an item or service delivered or undertaken primarily to treat a medical condition or to maintain or restore functional ability. For this definition n of medical necessity, a health intervention shall be determined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied.

C) **"Health outcomes"** means treatment results that affect health status as measured by the length or quality of a person's life.

Medicare – The federal government health insurance program for certain aged or disabled clients under Titles II and XVIII of the SSA. Medicare has two parts:

A) Part A covers the Medicare inpatient hospital, post-hospital skilled nursing facility care, home health services, and hospice care.

B) Part B is the supplementary medical insurance benefit (SM B) covering the Medicare provider's services, outpatient hospital care, outpatient physical therapy and speech pathology services, home health care, and other health services and supplies not covered under Part A of Medicare.

Member – A current or previous member of UnitedHealthcare Community Plan.

NCQA – National Committee for Quality Assurance

Participating Provider – A provider that has a written agreement with UnitedHealthcare Community Plan to provide services to members under the terms of their agreement.

Provider Group – A partnership, association, corporation, or other group of providers.

Physician Incentive Plan – Any compensation arrangement between a health plan and a provider or provider group that may directly or indirectly have the effect of reducing or limiting services to members under the terms of the agreement.

Preventive Care – Health care emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including routine physical examination and immunization.

Primary Care Provider (PCP) – A participating provider responsible for supervising, coordinating, and providing primary health care to members, initiating referrals for specialist care, and maintaining the continuity of member care. PCPs include, but are not limited to; pediatricians, family providers, general providers, internists, provider assistants (under the supervision of a provider), or advanced registered nurse practitioners (ARNP), as designated by UnitedHealthcare Community Plan.

Quality Improvement Program (QIP) – A formal set of activities provided to assure the quality of clinical

and non-clinical services. QIP includes quality assessment and corrective actions taken to remedy any deficiencies identified through the assessment process.

Remittance Advice (RA) – Written explanation of processed claims.

Referral – The practice of sending a patient to another provider for services or consultation which the referring provider is not prepared or qualified to provide.

Rural Health Clinic (RHC) – A clinic, located in a rural area, designated by the Department of Health as an area having either a shortage of personal health services or a shortage of primary medical care. These clinics are entitled to receive enhanced payments for services provided to enrolled members.

Service Area – A geographic area serviced by UnitedHealthcare Community Plan, designated and approved by Iowa Department of Health

Specialist – Any licensed provider, who practices in a specialty field such as Cardiology, Dermatology, Oncology, Ophthalmology, Radiology, etc.

Sub-Contract – A written agreement between a health plan and a participating provider, or between a participating provider and another sub-contractor, to perform all or a portion of the duties and obligations a plan is required to perform pursuant to the agreement.

Tertiary Care – Care requiring high-level intensive, diagnostic and treatment capabilities for adults and/or children, typically administered at highly specialized medical centers.

Third Party Liability (TPL) – A company or entity other than UnitedHealthcare Community Plan liable for payment of health care services rendered to members. UnitedHealthcare Community Plan will pay claims for covered benefits and pursue a refund from the third party when liability is determined.

Title V – The portion of the federal SSA that authorizes grants to states for the care of Children with Special Health Care Needs.

Title XIX – The portion of the federal SSA that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid.

Title XXI – The portion of the federal SSA that authorizes grants to states for State Children's Health Insurance Program.

Utilization Management (UM) – The process of evaluating and determining the coverage for and the appropriateness of medical care services, as well as providing assistance to a clinician or patient in cooperation with other parties, to ensure appropriate use of resources. UM includes prior Authorization, concurrent review, retrospective review, discharge planning and case management.

Women's Health Care Services – Women's Health Care Services is defined to include, but need not be limited to, maternity care, reproductive health services, gynecological care, general examination, and preventive care as medically appropriate, and medically appropriate follow-up visits for these services. General examinations, preventive care, and medically appropriate follow-up care are limited to services related to maternity, reproductive health services, gynecological care, or other health services that are particular to women, such as breast examinations. Women's health care services also include any appropriate health care service for other health problems, discovered and treated during the course of a visit to a women's health care practitioner for a women's health care service, which is within the practitioner's scope of practice. For purposes

of determining a woman's right to directly access health services covered by the plan, maternity care, reproductive health, and preventive services include, contraceptive services, testing and treatment for sexually transmitted diseases, pregnancy termination, breast-feeding, and complications of pregnancy.